Maternal and Child Health Services
Title V Block Grant

State Narrative for Ohio

Application for 2011
Annual Report for 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The assurance and certifications for Ohio can be made available by contacting

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D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

E. Public Input
The Ohio Department of Health made the FFY11 MCH BG application, including the Needs Assessment, available for public input through various traditional and non-traditional venues. The MCH BG application was placed on the ODH webpage, and the MCH BG Coordinator was listed as a point of contact for individuals wishing to send feedback directly to ODH. A link was placed on the ODH Webpage offering the public an opportunity to participate in a survey regarding the MCH BG application via Survey Monkey. Preliminary results from the survey are attached to the application. Notification of the webpage posting was sent to the MCH Advisory Committee and MCH Needs Assessment stakeholders. Stakeholders represented DFCHS grantees, other state agencies, local organizations, provider and professional groups and to some extent, parents/consumers.
With the rise of social media outlets such as Face Book and Twitter, for the first time the MCH BG was placed on the ODH Face Book Page, allowing anyone who has added ODH as a friend, a chance to review and provide input on the application. Placing a notice on the ODH Face Book Page serves as a way of reaching a broader population and hopefully receiving more consumer and family input. And finally, for all those individuals who follow ODH on Twitter, ODH was able to "tweet" that the MCH BG is out for public input. The current application will be available on the ODH website at http://www.odh.ohio.gov/healthStats/data/needsassess/bgcommentsmain.aspx until the end of July.

Currently, ODH has received 22 responses from interested parties. Of those 22 responses 45% represents local Health Departments; 14% Parents/Parents of CSHCN; 13% WIC programs; 13% Community Health Center/Clinic; 9% Health Care Providers, and the remaining 6% represented

various interested parties (e.g., University Faculty, Other State Agencies, Schools and other Community Based Organizations). Survey responders have provided ODH with feedback that will help inform how we move forward with activities related to the performance measures. The only concern that has been identified is related to National Performance Measure 08: The rate of birth (per 1,000) for teenagers aged 15 through 17. A provider asked that ODH include evidence-based programs that teach teens to avoid premarital sexual activity and other risk behaviors that contribute to teen pregnancy and evidence-based healthy relationship education to train FP nurses to provide prevention education of sexual coercion as part of our activities.

In response to this request ODH shared the following information with the provider and invited them to join our Action Learning Collaborative: Ohio was one of six (6) states selected in 2009 to participate in the Preconception Health and Adolescents Action Learning Collaborative sponsored by the Association of Maternal and Child Health programs (AMCHP), the Association of State and Territorial Health Officials (ASTHO) and the Centers for Disease Control and Prevention (CDC).

These states are working to integrate preconception health recommendations into their adolescent health efforts. Preconception health efforts are those strategies aimed at promoting the health and preventing disease among women, men and families in the period before a pregnancy occurs. The Action Learning collaborative (ALC) model brings together multidisciplinary teams for an 18-24 month period to analyze a problem in maternal and child health, identify resources, learn how to apply problem-solving techniques to that issue, review promising practices from other teams and create plans to address specific public health problems. Funding has been provided to support state teams through 2010.

Overall, the input received has been very positive, and ODH has received 9 letters of support for the FFY11 MCH BG application. Letters of support were sent by the following organizations:

1) Board of Health, Belmont County General Health District, St. Clairsville, Ohio
2) City of Cincinnati Health Department, Southwest Regional Resource Center, Cincinnati, Ohio
3) Clark County Combined Health District, Springfield, Ohio
4) Department of Public Health Division of Environment, Cleveland, Ohio
5) District Board of Health, Mahoning County Childhood Lead Poisoning Prevention Program, Youngstown, Ohio
6) Prevent Blindness Ohio, Columbus, Ohio
7) Toledo-Lucas County Health Department, Toledo, Ohio
8) Seneca County General Health District, Northwest Ohio Regional Resource Center, Tiffin, Ohio
9) Zanesville-Muskingham County Health Department, Zanesville, Ohio

Copies of the letters are kept on file in the DFCHS Office and are available upon request.

An attachment is included in this section.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

During 2007 and 2008, in anticipation of the Fiscal Year 2011 Maternal and Child Health Block Grant (MCH BG) application, Ohio conducted a comprehensive assessment of the health needs of women and children in the state. The assessment consisted of various components including a review of the data on a wide variety of health issues, a review of Ohio and national demographic data, consumer input through focus groups, key stakeholder opinions and professional judgment from those working in the field.

To determine the most critical needs of the state's maternal and child health population Leadership within the Ohio Department of Health (ODH) Division of Family and Community Health Services (DFCHS) Chiefs (division chief, seven bureau chiefs and an external facilitator) collaborated on the most effective way to include partners in a structured prioritization process. Five (5) key areas were identified as being essential for a successful outcome: The convening of four (4) day long stakeholder meeting's focused on prioritized health issues; Sharing of data that outlined health social indicator status, health and social services access related to the MCH population from an Ohio and national perspective; Identifying best, promising or evidence based practices implemented across the state for the MCH population; Utilizing a drilled down and analysis approach to identifying potential interventions related to the prioritized health issues.

The primary role and responsibilities of Leadership were to elicit data, information, opinions, and perspectives from key stakeholders, who are well informed and concerned about; 1) the needs of Ohio's maternal and child health (MCH) populations, 2) the existing MCH service system and resources that exists in the state, and/or 3) the existing political context and other environmental factors that affect the implementation of policy and programmatic changes. Utilizing break-out sessions represented by the MCH population, participants from across the state representing state agencies, foundations, insurance providers, professional organizations, local public health agencies, and other affiliated organizations drafted agreed upon list of prioritized health issues for the sub-population being discussed. There were several additional face to face and web based meetings that lead to the identification of five critical priorities for each MCH population. These rankings were then forwarded to DFCHS Leadership for their use in the final selection of the state's 7 - 10 MCH priorities.

Over the next several months a series of facilitated meetings took place by the DFCHS Leadership to discuss and rank the priorities identified by the stakeholder group. They were able to collectively identify the state's 9 critical MCH priority needs. These 9 critical priorities fall within 3 categories: Category A. Improve the health of children and adolescents (e.g., obesity, STD, oral health, decreasing deaths, improving health outcomes). The priorities under category A are: 1) Increase physical activity and improve nutrition; 2) Increase breastfeeding initiation and duration rates; 3) Improve early childhood development. Category B. Increase positive pregnancy outcomes and preconception health (e.g., decrease infant mortality and decrease premature births). One priority falls under category B, 4) Decrease rate of smoking for pregnant women, young women and parents. Category C. System Improvement. The majority priorities fall under category C, 5) Increase the viability of the health care safety net; 6) Increase the number of women, children and adolescents with a health home;
7) Increase access to evidence based community prevention programs; 8) Increase successful transition of special needs children from pediatric/adolescent to adult health care systems; 9) Improve the availability of useful and accurate health care data and information (this relates to

quality and capacity).

Many of the needs that were high priority in the last Needs Assessment continue to be priorities, and are reflected in the new state performance measures, however most have been replaced with broader needs statements. Priorities such as "enhance social/emotional strengths of families" and "Promote collaboration and coordination of programs through partnerships and data integration" continue to be addresses as filters that run through all the priorities, performance measures and programming activities. The new areas that have emerged as priorities were identified across all population groups as a critical need such as access to care and overall healthcare, appropriate insurance coverage.

Therefore, priorities that assure quality screening; identification, intervention, care coordination, medical homes, and access to comprehensive and preventive treatment services for individuals, and families, including CSHCN emerged as the focus during this needs assesment. In addition all stakeholder groups emphasized the importance of reducing disparities, and this need will be addressed within an on-going state performance measure. The Ohio MCH Title V program has begun active planning and implementation for the items raised during this Five Year Needs Assessment.

An attachment is included in this section.

III. State Overview
A. Overview
Section III. A. Overview

As the flagship of Ohio's public health infrastructure, the Ohio Department of Health (ODH) works with 129 local health departments to promote its mission statement "to protect and improve the health of all Ohioans by preventing disease, promoting good health, and assuring access to quality health care". Ohio's Title V MCH Program embodies the states mission, and fully embraces the charge of improving healthcare for the populations it serves as exemplified by the nine priorities that have been selected. In addition Governor Strickland has set 12 priorities for the state of Ohio, and of those 12 the Title V MCH program aligns with 3; Health Care, Helping Ohio's Most Vulnerable, and Diversity.

ODH is a cabinet agency, and the director reports to the governor. ODH is organized by three program divisions and six offices. Program divisions are the Division of Family and Community Health Services, Division of Prevention and Division of Quality Assurance. The offices are Employee Services, Financial Affairs, Management Information Systems, General Counsel, Performance Improvement and Healthy Ohio, a Governor appointed Program housed at ODH. Healthy Ohio has three core program areas: health promotion, disease prevention and health equity. These areas work collaboratively with public and private partners and consult with the Healthy Ohio Advisory Council to create the changes in communities, worksites and schools that lead to better health for all Ohioans.

ODH has selected "Strengthen Program and Service Impact" as one of its strategic objectives that relates to the Maternal, Child, Health population. The key activities related to this objective are: a) determine health status improvement targets, b) identify key populations to target, c) use approaches which best demonstrated effectiveness, d) assure use of multiple and/or innovative approaches, e) define measures and apply effective evaluation. In achieving this objective MCH staff are encouraged to use the following filters; strengthen and expand key partnerships, use data to drive decision making, quality improvement and accountability, and use resources to eliminate health disparities and pursue health equity.

The health of Ohio, in comparison to other states, falls largely in the middle. Because of the size of the state and the demographics, Ohio does very well on some measures, and poorly on others. According to the United Health Foundation's America's Health Rankings, in 2009 Ohio ranked 33rd in the nation up from its ranking of 34 in 2008. Ohio continues to have a low rate of uninsured population and a high rate of high school graduation, but the prevalence of smoking and the percentage of children living in poverty have increased. Disparities in Ohio continue to persist. For example, the prevalence of low birth weight and the cardiovascular death rates are higher among non-Hispanic blacks than other races.

Demographics
The 2009 estimated population of Ohio was 11,542,645, giving the state a population density of 281.9 people per square mile. Ohio ranks as the seventh-most populous state among the 50 states and the District of Columbia. By 2030, Ohio is projected to remain the seventh-most populous state, with an estimated 12.3 million people. Between 2000 and 2030, the state expects to gain 254,616 people through migration. Females in Ohio accounted for 51.2 percent of the total population in 2008. Twenty-five to 64-year-olds make up 52.6 percent of the female population. Women age 65 years and over comprised 15.7 percent of the female population. Females 15-24 years of age make up 13.1 percent, females 5 to 14 years of age make up 12.5 percent and females younger than 5 make up 6.2 percent of the female population. An estimated 81.1 percent of the population in Ohio resides in metropolitan areas. The 10 counties with the largest populations are Cuyahoga, Franklin, Hamilton, Montgomery, Summit, Lucas, Stark, Butler, Lorain and Lake. The 88 counties are categorized as metropolitan (11), suburban (16), rural non-

Appalachian (29) and Appalachian (32).

Since 1990, Ohio has had an increase in ethnic minorities as a percentage of the population. The Hispanic population, composed mainly of persons of Mexican and Puerto Rican origin, has grown 22.4 percent since 2000. Likewise, since 2000, the black population has grown 5.6 percent. The three largest groups of Asian populations in Ohio are of Indian, Chinese and Vietnamese origin. In 2008, 86.6 percent of the population was white, 8.0 percent was black, 0.8 percent was Asian and 1.6 percent was Native American and Alaskan Native. These groups may also include Hispanics who made up 2.3 percent of the population. There are several special populations of note in Ohio. The migrant population continues to slowly increase. Between 2003 and 2004, this population increased by 4%. Ohio is also home to the nation's largest concentration of Amish, with about 40,000 residing in a five county rural area. Holmes County alone is home to 19,000 Amish. Ohio has also experienced an influx of immigrants, both from primary resettlement of refugees as well as secondary migration from other states.

Ohio's age distribution has gone through a change in the past 10 years. The first half of the baby-boom generation has moved into empty-nester household stage. The 65 and over age group has experienced the slowest growth in three decades due to inclusion of smaller WWII veteran and Great Depression cohorts. Gaining only 3.2 percent growth statewide, growth in the under-18 age group is limited to areas of larger total population growth. Ohio births have declined from the baby boom high of about 243,000 in 1957 to just over 148,000 in 2008. In 2008, the population of children through age 24 was 3,812,111 representing 33 percent of the total population. Youth as a percentage of the state population is projected to continue to decrease. This trend is consistent with the national trend.

According to ODH Vital Statistics, there were 148,592 live births to Ohio residents in 2008. By mother's race, births were distributed as follows: white, 75.7%; black, 15.9%; all other races, 8.4%. The Ohio resident live birth rate decreased over the period 1994 to 2008, from 14.3 births per 1,000 population, to 12.9 per 1,000. The white rate followed the same pattern, while the black rate declined until 2003, at which point it increased from a low of 16.1 births per 1,000 to 18.1 in 2008. In 2008, Hispanics experienced the highest live birth rate of all racial/ethnic groups examined, and this was the only group with a marked increase across the period. This finding is consistent with national birth trends. Implications: Hispanic birth outcomes will exert greater influence on overall Ohio birth outcomes assuming the Hispanic population continues to represent an increasing proportion of Ohio births over time. While, the proportion of all births that were Hispanic increased 2.7 fold between 1994 and 2008, Hispanics still represented only 4.6 percent of all Ohio live births in 2008.

Ohio has 4,508,871 total households. A household consists of all the people who occupy a housing unit. A household may include the related family members and all the unrelated people, if any, such as lodgers, foster children, wards or employees who share the housing unit. A person living alone in a housing unit, or a group of unrelated people sharing a housing unit such as partners or roomers, is also counted as a household. There are two major categories of households, "family" and "non-family." Sixty-five percent of Ohio households are family households; approximately 31.6 percent of family households include children under the age of 18 years. Forty-eight percent of family households are married-couple families; 16.8 percent are single-parent households. Approximately 33.8 percent of these single-parent households are female householders with no husband present (this excludes single women who live with the child's father and single teenage moms who live with a parent or other relative). The percentage of births to single mothers has increased from 34.0 in 1997 to 43.2 in 2008. The number of single mothers in Ohio has increased 3 times since 1960, to 704,965 in 2008. In Ohio, 78.2 percent of all black births were to single mothers, whereas 36.3 percent of all white births were to single mothers according to 2008 records.

According to the 2005/2006 National Survey of Children with Special Health Care Needs (CSHCN), the total number of children with special health care needs in Ohio was 445,205 or

16.2 percent of children under 18 years of age. The survey identified 381,667 Ohio households with children with special health care needs or 23.9 percent of the state's households. In comparison, the survey identified 10.2 million children with special health care needs nationally or 13.9 percent of children under 18 years of age. Nationally, 21.8 percent of all households had a child with a special health care need.

The percentage of Ohio women who work continues to increase, with 60 percent of the female civilian population over age 16 participating in the labor force in 2004, up from 58 percent in 1994. The percent of women in the labor force is projected to continue to increase over the next 10 years. Ohio Asian women lead in pursuing higher education with 31 percent of those 25 years and older holding at least a bachelor's degree, compared with 15.6 percent of non-Hispanic white women, 9.6 percent of black women and 11.3 percent of Hispanic women. In 2008, for those 25 years and older, the educational levels of women are lower than men. Roughly 28.8 percent of women in this age group have completed college compared with 30.1 percent of men.

In 2008, 13.3 percent of Ohioans were living below the federal poverty level. This is similar to the national rate of 13.2 percent. The poverty level; however, varies greatly by county. The five counties with the highest poverty rates were Athens (29.6 percent), Vinton (23.0 percent), Adams (21.9 percent), Morgan (21.1 percent) and Jackson (20.7 percent). The five counties with the lowest poverty rates were Delaware (4.9 percent), Medina (5.8 percent), Warren (6.6 percent), Geauga (6.9 percent), and Union (7.1 percent).

Within metropolitan areas, the average poverty rate for Ohio cities was 18.9 percent, compared to 6.5 percent for areas outside of the central cities. Eight central cities had poverty rates greater than 20 percent: Cleveland (26.3 percent), Bowling Green (25.3 percent), Kent (25.2 percent), Youngstown (24.8 percent), Dayton (23.0 percent), Lima (22.7 percent), Cincinnati (21.9 percent) and Steubenville (20.4 percent). The counties with the highest poverty rates are located in Appalachian Ohio. Two-thirds of Ohio's poor are white, yet this racial group has the lowest poverty rate--10.8 percent in 2008. The poverty rate was 29.3 percent for blacks, 12.3 percent for Asian and 24.8 percent for Hispanics. The risk of poverty varies by the type of household in which people live and whether they have children. Although not generally considered a minority group, residents of Appalachian counties differ from other Ohioans. A report by the Central Ohio River Valley Association mapped the mortality rates in southern Ohio's Appalachian counties. These areas showed higher death rates due to all causes compared with overall Ohio rates. Factors contributing to higher rates included poverty, lack of health services, lack of health insurance and possible lifestyles and health behaviors of Appalachian Ohioans.

Families with children are at greater risk of being poor than families with no children and the risk among families headed by a woman with no spouse present is much larger. Those with at least one child had poverty rates only three to ten times higher than the rates of those with no children. The age groups characterized by higher-than-average poverty rates are children (ages 0 to 17 years). The higher poverty rate for children may be partly explained by the larger proportion of one-parent families. Children are the poorest people in Ohio: 18.5 percent of children under 18 years old lived below the poverty level in 2008. The poverty rate for the total population decreased from 1994 (14.2 percent) through 2008 (13.4 percent). Overall, the rate for children under 18 years decreased from 1994 (20.9 percent) through 2008. Of the 2,936,172 families currently estimated to be below the poverty level, 48.5 percent of those families have related children younger than 18 years of age.

There were 389,259 families with female heads of household that fell below the federal poverty level in 2008. Approximately 68.5 percent of families with female heads of household had related children 18 years of age and younger. The unemployment rate in Ohio was 10.8 percent in January 2010, which was higher than the national average of 9.7 percent for the period. Since January 2006, when the unemployment rate was 5.4, Ohio's unemployment rate has risen drastically, which is consistent with the national trend.

Like other states, Ohio suffers from a shortage of primary care, dental care and mental health care providers in a number of communities and counties. Attempts at enumerating shortage areas center on those that have gone through the process of being designated a federal Health Professional Shortage Area (HPSA). The data; however, does not present the whole picture because many areas that might qualify as HPSAs do not apply. (A full description and the HPSA maps are more thoroughly discussed in the Needs Assessment) Ohio has 127 total primary care HPSA's located in 51 of its 88 counties. Eleven are whole county, 21 geographic but not the whole county, 34 are for special population groups, and 58 are facility HPSAs. They include much of rural Ohio and parts of every major city in Ohio (Cleveland, Cincinnati, Toledo, Columbus, Dayton, Youngstown, Akron and Canton). The 98 dental HPSAs in 46 counties are more evenly distributed with 29 located in metropolitan areas and 30 located in non-metropolitan areas. In Ohio, disparities in oral health and access to care have been linked to low family income, residence in an Applachian county, and race. Ohio has 65 mental health HPSA's: 7 whole county, 12 geographic areas, 4 special population, and 42 facilities. Thirteen geographic designations indicate a need for 19 psychiatrists to serve a population of more than 907,000 Ohioans. Of the 19 counties within these geographic designated areas, 12 are in the Appalachian region. The remaining three mental health HPSAs have been designated for facilities (one state prison and two state psychiatric hospitals).

Title V Health Care Delivery Environment:
As noted, Ohio has a large population of women of childbearing age, children, and children with special health care needs, making its Title V MCH program critical to the health of a large portion of the state's population. Sometimes influencing care (e.g., through partnership s with Medicaid, Mental Health and the Department of Developmental Disabilities) sometimes through funding services to fill gaps in the safety net (e.g., family planning, prenatal child health, and children with special health care needs); and in a two small instances providing care directly (e.g., vision, hearing clinics). Dollars expended on direct service at the local level are used to augment the publicly-funded safety net. Medicaid and other third party payers are billed by local clinics, while Title V funds are used for those persons who have no other means of paying for services. These grantees are often local health departments, but they may also be hospitals, community action agencies, and other non-profit community agencies.

Ohio's Title V Program is able to work within these programs and initiatives and has become more efficient and responsive to the needs of the MCH population. For example, within the Child and Family Health Services (CFHS) program, local agencies that receive Title V funds are familiar with MCH Block Grant performance measures and prepare their grant applications to ODH by population group and level of the MCH service pyramid, based upon their own county-level needs assessment. The CFHS Program is a network of clinical service providers, and local consortiums of health and social services agencies that identify the health needs, service gaps, and barriers to care for families and children and then plan clinical and community public health services to meet those needs. It also assures clinical child and adolescent health, prenatal, and family planning services for some low income families and children (e.g., legal immigrant children, and pregnant women, ineligible for Medicaid by federal mandate even if otherwise meeting family income guidelines). Funding of 71 local sub-grantees is done with a combination of Title V and state general revenue dollars. CFHS consortiums are linked to the county Family and Children First Councils, Medicaid, and the Help Me Grow program. CFHS Projects are necessary even though Medicaid provides substantial funding of health care for the MCH population. For those children residing in Medicaid mandatory managed care counties, the CFHS clinics are one of the choices that the family would have for a child health care provider. In many rural counties however, the CFHS clinic may be the only provider in the community who will accept Medicaid eligible clients, and those with no ability to pay for services.

ODH has been working with the six Regional Perinatal Centers for the past decade to address perinatal quality improvement by stimulating the use of data to identify needs and then implement and evaluate interventions based on current evidence. Progress has been made in developing Ohio's capacity to address perinatal health in this way. Ohio is now ready to take this approach to

the next step and apply the quality improvement science in a broader way. In order to expand the effort, ODH will be redirecting the funds that currently support the Regional Perinatal Centers and the quality improvement work to an enhanced initiative in partnership with Ohio Medicaid. This will allow the state to draw down a federal match which will significantly increase the total investment. ODH will work with partners to establish a network of Quality Improvement Coordinators to support the spread of the quality improvement science approach and the various QI projects currently underway.

Federally Qualified Health Centers (FQHCs) play a vital role in the delivery of primary and preventive care to pregnant women, mothers, infants, children, adolescents, and CSHCN. Financial resources are distributed to provide improved access to health care for the Maternal and Child population. A total of 88,897 unduplicated patients (pregnant women, children less than 1 year old and children 1-18 years old) received care in FQHC's or in the free clinics throughout the state in 2007.

Currently there are 129 local health departments in Ohio. Sixty-four of Ohio's 88 counties have one health department. The other 24 counties contain 65 departments, an average of nearly three per county (for the 24 counties). Ohio is a "home rule" state; the state health department does not have authority over local health departments except through some statutory requirements for environmental health and subsidy. ODH implemented Local Health Department Improvement standards available at http://www.odh.ohio.gov/LHD/PSWstan.pdf which do not represent an increase in the number of standards pertaining to subsidy, but they do represent a change toward a continuous quality improvement approach. The Ohio Department of Health is participating as a beta site for testing the new public health standards, as developed by the Public Health Accreditation Board.

Title V FFY 2011 MCH Needs Assessment, Priorities and State Performance Measures
During 2007 and 2008, in anticipation of the Fiscal Year 2011 Maternal and Child Health Block Grant (MCH BG) application, Ohio conducted a comprehensive assessment of the health needs of women, children and families in the state. The assessment consisted of various components including a review of the data on a wide variety of health issues, a review of Ohio and national demographic data, consumer input through focus groups, key stakeholder opinions and professional judgment from those working in the field. The needs assessment process and resulting priorities have been used to guide Ohio's MCH BG funded activities and grant application for 2011.

To determine the most critical needs of the state's maternal and child health population leadership within the Ohio Department of Health (ODH) Division of Family and Community Health Services (DFCHS) (division chief, six bureau chiefs and an external facilitator) collaborated on the most effective way to include stakeholders in a structured prioritization process. Five (5) key areas were identified as being essential for a successful outcome: the convening of four (4) day long stakeholder meetings including; sharing of data that outlined health social indicator status, health and social services access related to the MCH population from an Ohio and national perspective; identifying best, promising or evidence based practices implemented across the state for the MCH population; utilizing a drilled down -analysis approach to identifying potential interventions related to the prioritized health issues; the incorporation of an evaluation tool at each phase of the process to determine what worked and what didn't.

ODH initiated the MCH Block Grant needs assessment process well in advance of the FFY 2010 submission. In the summer of 2008 Ohio's Title V leadership assembled to develop plans and timelines for completing the BG needs assessment and application for the July 2010 deadline. During October-December 2008, meetings were held to engage stakeholders in discussions around the prioritized health issues within four maternal and child health areas of concern; early childhood; school-age children, adolescents and young adults; children with special healthcare needs; and women's health, birth outcomes and newborn health. Each session included participants from across Ohio representing state agencies, foundations, insurance providers,

professional organizations, local public health agencies, consumer, and other affiliated organizations. The product from each group discussion was an agreed upon list of prioritized health issues for the sub-population being discussed. ODH provided stakeholders participating in the prioritization process with a compilation of quantitative data specific to their population group. The data were primarily organized into topic areas in a fact sheet format. Data sources included state and national Vital Statistics, PRAMS, Youth Risk Behavior Survey (YRBS), www.cdc.gov/nccdphp/dash/yrbs/index.htm, Behavioral Risk Factor Surveillance Survey (BRFSS), www.cdc.gov/brfss/technical_infodata/surveydata.htm, Ohio Family Health Survey (OFHS), http://grc.osu.edu.ofhs, Census, Disease Surveillance and ODH program statistics.

Prior to each face-to-face meeting, participants were engaged in an individual-level issue prioritization exercise. They were provided with a list of 25 pre-identified health issues for the sub-population they were invited to represent. Individuals then ranked these 25 issues in importance using the "Q-sort" method. Mean rankings and standard deviations for each mean were calculated prior to each face-to-face meeting. To begin the discussion of health issues, participants reviewed a compiled list of health issue feedback gathered from a separate stakeholder survey conducted by ODH. This information was sought from practitioners and providers across Ohio and provided a local perspective to the issues for each sub-population. All groups except the early childhood stakeholders generated a list of recurring themes within these local stakeholder survey results. This list was used as a reference point throughout the issue prioritization phase of the meeting that followed. After reviewing and generating a list of recurring themes from the local stakeholder survey, participants were provided with the results of their Q-sort exercise. After a brief discussion of the results in general, the participants began a discussion of individual issues.

Staying connected to the process, using legislative mandates, and political and community driven concerns as a filter, MCH Leadership collectively identified the state's nine critical MCH priority needs. These nine critical priorities fall within three categories; improve the health of children and adolescents; increase positive pregnancy outcomes and preconception health; and system improvement. The nine priorities are not ranked in any specific order of importance within and/or among Categories: 1) Increase physical activity and improve nutrition, 2) Increase breastfeeding initiation and duration, 3) Improve early childhood development, 4) Decrease smoking among pregnant women, young women and parents, 5) Increase the viability of the health care safety net, 6) Increase the number of women, children and adolescents with a health home, 7) Increase access to evidence based community prevention programs, 8) Increase successful transition of special needs children from pediatric/adolescent to adult health care systems, 9) Improve the availability of useful and accurate health care data and information (specifically related to quality and capacity). Once the critical priorities were identified, MCH Leadership selected the new FFY 2011 -- 2015 State Performance Measures (SPMs) that reflect both a community and professional perspective around maternal child health care needs in Ohio. Throughout the process the Division and Bureau Chiefs played a pivotal role in connecting with the stakeholders at every level, and they ensured that stakeholder questions and concerns were appropriately addressed while adhering to and sharing the political and legislative mandates that govern ODH. This process allowed ODH to select performance measures and action plans, which will drive its allocation of resources and monitor the progress and outcomes of Ohio's MCH population.

Title V Current or Emerging Challenges
While conducting the needs assessment ODH identified major challenges that participants (including youth, parent and family members, professionals, policy makers, and MCH program staff) felt were impacting the delivery of healthcare services. Global challenges revolved around the diminishing access to health care and health-related services across the state, the significant cuts to and availability of funding for MCH services and the current state of the economy.

Some of the challenges by population consist of the following; Early Childhood, School-age, Adolescents and Young Adults: low-income children and adolescents getting access to dental care, obtaining health insurance coverage, comprehensive services including immunizations, oral

health, vision, hearing, lead screening, behavioral and mental health screening, providers accepting Medicaid, public awareness and information and trainings, the identification that motor vehicle crash is the leading cause of unintentional injury related death among children 14 years and under. Children with Special Health Care Needs: lack of adequately trained pediatric providers in some geographic areas, lack of family and provider resources in Appalachia, rural, inner city, reduced funding in recent years is impacting outreach and services to families, lack of funding for those portions of health care services not covered by other funding services, including physical, occupational, speech, behavioral therapies, special equipment and medical supplies, assistance with navigating benefit systems regarding services and eligibility requirements, coordination among complex government programs, access to providers. Women's Health, Birth Outcomes and Newborn Health: diminishing financial support, erosion of local programs, resistance of schools to fully address use of contraceptives, lack of prenatal care providers, overall Ohio economy, providers not accepting Medicaid, obtaining culturally appropriate family planning materials, communities having healthcare workers to improve access to care, quality data and information for policy development and program planning for legislators. A comprehensive list of identified challenges by population groups can be accessed by viewing the Needs Assessment of Ohio's Maternal and Child Health Populations.

B. Agency Capacity

Section III B. Agency Capacity

Methods for assessing MCH populations & Determining Agency Capacity
Ohio utilizes the Community Health Improvement Cycle model to review and assess its capacity for delivering essential services. The model dictates a process built on self assessment; external assessment; building partnerships; planning; data needs/capacity; priority setting; action plan/interventions; implementation and evaluation. DFCHS engaged the MCH Advisory Council whose primary role is advising on block grant funded programs and the population served by the Title V Program to participate in the review and assessment process. The Council is composed of maternal and child health consumer and family members, professionals in both public and private sectors, clinicians, administrators, policy makers, MCH advocates, state agency representatives, academicians and state legislators and appointed by the Director of Health.

The most important health care needs and issues were identified by population group, and resulted in a comprehensive assessment of the state's maternal and child health population. A final prioritization of participant-generated health issues can be found in the FFY11 Needs Assessment. Below by population are some of the priority health issues and agency recommendations:

Early Childhood, School-age, Adolescents & Young Adults - Priorities: Increase access to adequate & culturally appropriate prevention, early identification, treatment services; prevent unsafe behaviors such as substance use, risky sexual behaviors, violence & behaviors most likely to cause intentional/unintentional injuries/illness; provide family-centered services/education to support child/family health/wellbeing; recognize/reduce the negative impact of social determinants of child & adolescent health; reduce environmental exposures that contribute to chronic illness, injury & disability. Recommendations: identify successful prevention programs based on or informed by an existing body of evidence & link programs through a network of partners; identify/encourage best practices related to access/utilization of child/adolescent health services; identify strategies/incentives to promote multi-disciplinary collaboration/coordination at the local regional/state levels; build body of Ohio-specific evidence/data for cost-effectiveness of prevention, include a case management/care coordination component in appropriate programs to increase patient/family compliance & overall access to appropriate care.

Children with Special Health Care Needs (CSHCN) - Priorities: Increase number of standardized medical homes for CSHCN; increase capacity for the medical home to screen, diagnose/access comprehensive medical/non-medical specialty services through the use of evidence based tools; provide families with support & networks needed to participate in all aspects of family care; enhance system of reimbursement for basic primary care services, provide incentives for innovative service delivery; improve capacity to collect/utilize available CSHCN data to drive future decision making. Recommendations: collect/analyze sub-county level data that shows how many CSHCN are living in Ohio & how many are currently left unserved; work with providers & other stakeholders to create a viable model, including funding, for the medical home that is multidisciplinary (i.e. medical, educational & social services); engage consumer & family advocates to expand & support sustainable patient & family advocate/navigator programs; partner with private entities & other non-traditional partners to leverage expertise in system development.

Women's Health, Birth Outcomes & Newborn Health - Priorities: Provide comprehensive reproductive health services/service coordination for all women/children before, during/after pregnancy; eliminate health disparities & promote health equity to reduce infant mortality; prioritize/align program investments based on documented outcome/cost effectiveness; implement health promotion/education to reduce preterm births; improve data collection/analysis to inform program/policy decisions; increase public awareness about the effect of preconception health on birth outcomes; develop, recruit/train a diverse network of culturally competent health professionals statewide. Recommendations: Increase public utilization of resources such as the Ohio Benefit Bank to assist women/children with obtaining health care services; ensure access to providers, including advanced-practice nurses, who accept Medicaid & provide family planning services/care for high-risk pregnancies in all parts of Ohio; ensure that all women of childbearing age & their families have access to appropriate mental health services/substance abuse programs; implement/evaluate a social marketing campaign to increase public awareness of the prevalence of infant mortality & disparities that exist in Ohio; support implementation of the recommendations of Ohio Anti-Poverty Task Force; require any agency or group that receives public funding for MCH programs to identify measurable outcomes & publicly report their findings/outcomes.

ODH is the designated state agency for implementation of the Title V Maternal & Child Health Block Grant (MCH BG) & established the DFCHS for this purpose & for the purpose of ensuring provision of MCH programs at the state/local level. DFCHS is responsible for the following state statutes that impact the Title V program: 1) Birth Defects Information System (BDIS); 2) Child Fatality Review (CFR); 3) Lead Poisoning; 4) Save Our Sight Program; 5) Sudden Infant Death; 6) Universal Newborn Hearing Screening; 7) Vision/Hearing Screening; 8) Women's Health Services (WHS); 9) Shaken Baby Syndrome (SBS); 10) Abstinence & Adoption Education Guidelines; 11) Genetics Services Program & Sickle Cell Services Program.

PROGRAM CAPACITY - Bureaus within DFCHS are responsible for administering the MCH-related programs & coordination with non-MCH BG programs. DFCHS has approximately 60 different funding sources supporting its public health programs. To ensure ODHs capacity to promote & protect the health of mothers & children including CSHCN, & address the priority health issues, the following preventive & primary health care services are administered within DFCHS Bureaus through Ohio's Title V programs. The list of programs indicated below reflect the comprehensive, community-based, and family centered care provided by Ohio that is essential in protecting the health of all mothers, children and CSHCNs. ODH has selected 9 MCH Priorities that fall within 3 categories; improve the health of children and adolescents; increase positive pregnancy outcomes and preconception; and system improvement. These priorities were selected because they address the important health care needs and issues that were identified via the Needs Assessment process. All 9 priorities are reflected through the programs listed below. These programs are on-going and a broader description of each can be found by visiting the ODH website at www.odh.ohio.gov .

Birth Defects (BD) Information System (BDIS)
Child & Family Health Services Program (CFHS)
Healthy Child Care Ohio (HCCO)
Preconceptional & Interconceptional Health Services Family Planning (FP)
Prenatal Smoking Cessation Services Program (PSCP)
Primary Care/Rural Health Program (PC/RH)
Save Our Sight Program (SOS)
School Nursing (SN) Consultation
Services for Children with Special Health Care Needs (CSHCN)
Sickle Cell (SC) Services Program
Shaken Baby Syndrome Education Program
Special Supplemental Nutrition Program for Women, Infants, & Children (WIC)
Specialty Medical Services Program (SMSP)
Sudden Infant Death Program (SID)
Women's Health Services Program (WHSP)

While the programs listed above remain a part of Ohio's capacity to provide preventive and primary care services for its MCH population, the programs described below represent some of the new and innovative approaches to addressing the 9 MCH Priorities for FFY 2011 - 2015.

MCH Priorities 1, 3 and 7 are linked to and addressed through the following programs:

School and Adolescent Health Programs (SAH):
Action Learning Collaborative on Preconception Health for Teens:
The Preconception Health and Adolescents Action Learning Collaborative project sponsored by AMCHP in partnership with ASTHO is working to expand state-level preconception health efforts to include adolescents. Ohio is one of six state teams awarded this opportunity to receive technical assistance in creating strategies to implement the Centers for Disease Control and Prevention (CDC) Recommendations to Improve Preconception Health and Health Care with adolescent populations. ODH is partnering with the ODE to develop an adolescent health framework that can be used across sectors and disciplines to assist health care and education professionals in teaching health literacy to teens in a holistic manner. To view the draft framework go to: www.amchp.org/groups/Preconception-Health-Adolescents-ALC/Pages/default.aspx

Body Mass Index Surveillance Project:
School and Adolescent Health staff have developed a BMI surveillance program that involves obtaining heights and weights of 3rd and 7th graders throughout the state of Ohio. Childhood Obesity is one of the Governor's and Director of Health's top priorities. In addition physical activity and nutrition were the top priorities identified during the needs assessment process this past year. BMI data collection for the 3rd grade population occurs in conjunction with the Oral Health Program's Open Mouth Survey. By combining both surveys into one effort the ODH maximizes resources while limiting intrusion into schools. In addition to the third grade survey, which collects state and county level data, the School and Adolescent Health Section collects 7th grade BMI data at the state level every other year. The data are used by stakeholders and other ODH programs as a benchmark for evaluating progress and success of interventions targeted to impact childhood obesity. Training and technical assistance is offered to schools and local public health departments each year to assist in building local data collection efforts.

Nurse Impact SIIS Project:
School and Adolescent Health programs have improved schools ability to track immunizations using the Ohio Immunization Registry, Impact SIIS, thereby reducing the need for student exclusion from school. School Impact SIIS is a secure Web based, quality assurance tracking tool used by public and private sites in an effort to raise immunization rates and meet healthy people 2010 goals! ORC 3313.671 requires schools to collect satisfactory written evidence of student immunization according to ODH's approved schedule. Students without satisfactory immunization

documentation should be excluded after 14 school days until documentation is provided. Recent data from a small sampling of schools indicates that more than 68% of their student population was kept from being excluded for lack of immunization records.

Oral Health Initiatives:
ODH was notified in late August that the two HRSA grant applications submitted earlier this year were approved for funding starting September 1, 2010.
1. ODH received supplemental funds for the HRSA Workforce Grant initially awarded in Sept. 2009. These additional funds will be used for the same purpose as the current funds in this grant, to further restore funding cuts sustained in 2009 by the Safety Net and dental OPTIONS subgrant programs.

- OPTIONS funding will be restored to previous funding levels and some additional funding will be available. This will enable more uninsured Ohioans with low-incomes to receive needed dental care provided by volunteer dentists in their offices.

- Safety Net grant funds will be used to provide dental care to additional Ohioans who qualify for dental care through ODH- funded safety nets, primarily the uninsured and those with Medicaid. Safety Net grant applicants must document they are providing care to additional patients to receive an increase in funding from ODH.

2. Additionally, a new HRSA Workforce grant will support two new oral health initiatives: expansion of ODH's School-Based Sealant Program (S-BSP) and creation of a dentist loan repayment program.

- Currently Ohio's S-BSPs apply sealants to the teeth of about 28,000 children each year, 20,000 of which are served by ODH subgrant programs funded with MCH Block Grant funds (three programs are locally funded). The additional HRSA funds will enable ODH to expand the S-BSPs to serve approximately 40,000 students in high-risk schools. The S-BSP Expansion Plan includes a three-pronged approach which consists of

a. Maximizing the reach of the current infrastructure of ODH-funded programs by providing local agencies operating S-BSPs with additional funding to include additional eligible schools within their current area and/or to expand their respective service areas.
b. Funding new agencies to operate S-BSPs in areas, including multi-county, that are not in proximity to existing S-BSPs and have a critical mass of at least 2,000 2nd and 6th grade students enrolled in unserved eligible schools. (see attached map for expansion and areas identified for new programs)
c. Developing new approaches to reach schools that the current infrastructure cannot.

The dentist loan repayment program will be limited to dentists working full-time in federally designated dental Health Professional Shortage Areas (DHPSAs). See map of dental HPSAs. The current Ohio Dentist Loan Repayment Program (ODLRP), funded with a portion of dentist licensure fees, is limited as dentists choose to renew their contracts for 3rd and 4th year funding, allowing a very small number of new applicants to be funded. The timeline for this program is ambitious with dentist contracts starting by 2/1/2011. Additional information will be available on the Oral Health Section's Web page soon
http://www.odh.ohio.gov/odhPrograms/ohs/oral/oral1.aspx.

MCH Priorities 4, 5, 7 and 9 are linked to and addressed through the programs below:

Child Fatality Review (CFR) in Ohio: A Decade of Success
ODH honors the 10th anniversary of the Ohio CFR program which was established in 2000 in response to the need to better understand why children die. By 2002, CFR boards were organized in all 88 counties and began to review the deaths from all causes to children younger than 18. In 2005, Ohio was among the first states to begin using a national Web-based data

system developed by the National Center for Child Death Review. In 2009, the Ohio law was changed to specifically protect the confidentiality of CFR data at the state level, allowing ODH staff access to identifying case information that was previously shielded. This change will greatly enhance ODH ability to improve data quality and provide specific technical assistance to counties regarding their data. As of April, 2010, more than 13,000 Ohio reviews had been entered into the data system. The comprehensive nature of the data system allows detailed analysis of the circumstances and factors related to child deaths, which is included in an annual report submitted to the governor and posted on the Internet. The report has drawn national and international interest. Every year, dozens of local initiatives demonstrate that the multidisciplinary review CFR process results in actions to prevent future deaths. Ten years of successful CFR organization, process, collaborations and partnerships will provide a good foundation for the development of FIMRs, PAMRs and prevention initiatives into the next decade.

New Infant Mortality Consortium:
In November 2009 the Ohio Infant Mortality Task Force published its final report containing ten recommendations to lower infant mortality and disparities. The recommendations were developed with input from families and consumers who participated in the task force and provided a large number of comments through an on-line survey. One recommendation was to establish a permanent consortium to carry on with the work. This recommendation resulted in the creation in 2010 of an infant mortality consortium supported by ODH and structured around five workgroups addressing different aspects of the challenge, with oversight by an executive/steering committee. The consortium's work focuses on: Complete and coordinated health care throughout a woman's and child's life; Elimination of disparities in infant mortality and their underlying causes, including racism; Use of evidence-based practice and data to drive decisions; Public education about infant mortality and ways to decrease it; and Shaping public policy to impact infant mortality and disparities.

Membership consists of a wide array of Ohioans with a high level of interest and expertise in infant and women's health. There exists in the consortium a strong collective will to make changes to significantly improve the health of Ohio's women and infants and reduce the gaps in opportunities for good health between white and black populations. The consortium is off to a good start with the hope and expectation of measurable progress for our citizens in the future.

Regional Perinatal Quality Collaborative redesigns the Regional Perinatal Center Program (RPC):
ODH has been working with RPCs for several years to address perinatal quality improvement by stimulating the use of data to identify needs and then implement and evaluate interventions based on current evidence. The Ohio Perinatal Quality Collaborative (OPQC) evolved from these efforts and funding from a neonatal transformation grant helped further develop the collaborative, including setting up a data system and supporting optimal systems of care throughout Ohio. The RPC Coordinators served on the executive and steering committees of OPQC; recruited key stakeholders and families; facilitated regional face-to-face meetings; assisted in learning sessions; and reported progress. ODH is now ready to take this approach to the next step and apply the quality improvement science in a broader way.

ODH will build on the successes of OPQC and the training and technical assistance from national experts such as Kay Johnson and Dr. George Little. In order to further advance these and future projects, ODH plans to partner with Medicaid to focus on improving birth outcomes for the Medicaid population, and arranging Medicaid financing to significantly increase the total investment and establish a broader system of regional quality improvement professionals. ODH, Medicaid and the Ohio Colleges of Medicine Government Resource Center will work with medical schools, hospitals, and local public agencies to recruit and sponsor regional quality improvement professionals and support the implementation and evaluation of quality improvement interventions.

Transitioning to the Healthy Homes and Lead Poisoning Prevention Program:
The Ohio Childhood Lead Poisoning Prevention Program (OCLPPP) has made significant gains

toward the goal of eliminating childhood lead poisoning in the State of Ohio. In an effort to continue helping Ohio families have safe and healthy homes, the program is currently transitioning into the Ohio Healthy Homes and Lead Poisoning Prevention Program. (OHHLPPP).With many years of experience completing home environmental assessments and family education, the program is in a strong position to expand its programming to a holistic approach to housing.

Instead of restricting the program's focus to reacting to children who have already been negatively affected by their home environment, OHHLPPP has an ever-increasing focus on primary prevention activities. The primary concepts of a healthy home include keeping it dry, clean, safe, well-ventilated, pest-free, contaminant-free and well-maintained. The health issues related to housing can be reduced or eliminated with proper education, home maintenance, and/or testing.

Ohio is moving in a new direction and is leading the way for other states. Ohio coordinated with the Centers for Disease Control and Prevention (CDC) to acquire the Healthy Homes and Lead Poisoning Surveillance System (HHLPSS). The program will be deploying this new web-based surveillance system in the fall of 2010. By looking at the home as a whole system, the OHHLPPP will better be able to ensure that all Ohioans have access to a healthy and safe home.

MCH Priorities 6 and 8 are primarily addressed in the Bureau for Children with Medical Handicaps by the programs below:

There are many innovative and exciting examples of the Bureau for Children with Medical Handicaps (BCMH) contribution to developing, implementing and maintaining an effective and efficient safety net for Ohio's children with special health care needs. BCMH offers many services that are not consistently covered by other healthcare payers, yet offer a significant return on investment from both a fiscal and health status perspective. BCMH authorizes and provides reimbursement for nutrition consults provided by community dietitians, medication therapy management from a credentialed pharmacist, extended primary care management visits with physicians to support the medical home concept, and public health nurse visits. BCMH's statewide provider network includes hospitals, pharmacies, physicians, allied medical professionals, dentists, durable medical equipment dealers, public health nurses located in the local health departments, disease specific service coordinators located at the tertiary care centers (children's hospitals) and medical supply companies.

This list is not exhaustive, but it gives a sense of the breadth of the system of care that BCMH supports for Ohio's children with special health care needs. Licensed and Registered dietitians provide nutrition consults in the family home. These consults are designed to assess the nutrition status of the child and family and to educate them regarding the role of nutrition in the management of their specific disorder. In the home environment, the dietitian can observe the caregiver mixing a tube feeding, observe the child's eating skills, educate the family on ways to ensure their child receives the optimum nutrition to ensure the child reaches his/her highest levels of development and functioning. The dietitian becomes a key member of the healthcare team. In addition to home visits the dietitian can provide consultative services to the child's school nurse.

BCMH authorizes medication therapy management for clients with a diagnosis of either asthma or diabetes. The specially trained and credentialed pharmacist provides education on the drugs prescribed and any potential interactions, the proper procedures for drug utilization to ensure the client receives the maximum benefit per dose and reviews the pertinent patient history, medication profile (prescription and non-prescription), and recommendations for improving health outcomes and treatment compliance.
In support of the medical home, BCMH pays for extended physician care management care billing codes designed to ensure that physicians are able to spend an appropriate amount of time with children with special health care needs and their caregivers to coordinate needed services.

These billing codes afford the physician the opportunity for reimbursement for activities such as extended consultation with other providers, coordination of care among all providers of services and the ability to spend time consulting with the parents, schools or other providers.

Public Health Nurses employed by local health departments serve as a foundation of BCMH's family-centered community based service coordination model. BCMH pays these nurses to educate families and help them enroll on BCMH, Medicaid, Medicare, CHIP and all other potential health care payers. Additionally, these nurses provide training and education on condition-specific issues, help the family navigate the local care delivery system, identify ancillary services that provide value to the family (specialty transportation, skilled respite-care giver, etc). The public health nurses also work closely with the Service Coordinators and Early Intervention Specialists to address the multi needs of the Part C eligible children. These interactions have proven to be positive for the Early Intervention Specialists, the child's physician and the parents.

MCH Priorities 3, 5, 7 and 9 in particular are addressed through the following program, however all programs and priorities are impacted by culturally competent care:

Ohio's Capacity to Provide Culturally Competent Care: Ohio's MCH grantees must complete the Culturally & Linguistically Appropriate Services in Health Care (CLAS) standards self-assessment tool, based on 14 national CLAS standards. DFCHS Cultural Competency Strategy Workgroup assesses races, ethnicities & language of people being served in MCH programs, through a face to face survey process. Findings were drafted, recommendations identified/implementation will occur during FFY11. This infrastructure-level strategy will encompass the following activities: 1) update DFCHS profile of populations served by program, share the collection/reporting of racial/ethnic data, train DFCHS staff on data standards for purpose of improving collection of data on race/ethnicity across programs; 2) incorporate culturally appropriate activities/interventions into DFCHS programs; incorporation of core requirements of cultural competency, based on guidance from National Center for Cultural Competence (NCCC); train ODH staff & local grantees on requirements, for cultural/linguistic competence, & identification of tools to use to monitor progress; 3) development of a Title V program plan that maps out process in moving along continuum to cultural/linguistic competency. Plan will include guidance &/or tools for incorporating cultural/linguistic competence into each of the MCH BG national/state performance measures.

C. Organizational Structure

Section III C. Agency Organization

The Ohio Department of Health (ODH) is designated as the State agency responsible for administration of the Title V Maternal and Child Health Block Grant (MCH BG). Alvin D. Jackson, M.D., became director of the Ohio Department of Health (ODH) June 4, 2007, following his appointment by Governor Ted Strickland in January. Director Jackson is one of 26 directors or appointees who serve at the pleasure of Governor Strickland, who is currently in the 4th year of his 1st term as Governor of Ohio.

ODH is organized by Divisions and Offices, Offices report to Director Jackson, while all three Divisions at ODH are under the supervision of Michele Shipp, MD, MPH, PH.D. Prior to joining ODH in 2008, Dr. Shipp was Research Assistant Professor, Division of Health Behavior and Health Promotion in the Ohio State University College of Public Health. The Title V MCH BG is administered out of the Division of Family and Community Health Services (DFCHS), the table of organization for DFCHS is attached to this document, and can be found at

www.odhorgchart.odh.ohio.gov/OPE/WebApp/Modules/Chart/Chart.aspx. The MCH BG funded programs and positions are under the supervision of Karen Hughes, MPH, Ohio Title V Director, Chief of DFCHS.

Primary responsibility for MCH programs, under the Direction of the Chief of DFCHS:
Bureau for Children with Medical Handicaps (BCMH) administers programs that serve Children with Special Health Care Needs (CSHCN): including a Diagnostic, Treatment, and Hospital Based Service Coordination Program, supporting Team Based Service Coordination for conditions such as Spina Bifida and Hemophilia; Community Based Service Coordination, supporting Public Health Nurses in the Local Health Departments who assist families in linking to local resources and helping families navigate the health care system; Medical Home for CSHCN, supporting the efforts of local physicians to be Medical Homes for CSHCN. BCMH also houses programs specializing in Genetics which include: Genetic centers, that provide comprehensive care and services to people affected with, or at risk for genetic disorders. Genetic services include, but are not limited to genetic counseling, education, diagnosis and treatment for all genetic conditions and congenital abnormalities. Sickle Cell Services Program, Metabolic Formula, and Birth Defects Information System.

BCMH utilizes vital committees/council structure to foster open dialogue, receive input and feedback in regards to CSHCN needs across the state the committees are: Medical Advisory Council (MAC) -- members appointed by the Director of Health. The members represent various geographic areas of Ohio, medical disciplines and treatment facilities involved in the treatment of children with medically handicapping conditions; Parent Advisory Committee (PAC) -- composed of parents from around the state who meet regularly to advise BCMH. The mission of PAC is to assure that family-centered care is an essential component in the development and delivery of programs and services for CSHCN; Young Adult Advisory Committee (YAAC) composed of youths aged 16 to 24 who are receiving or have received BCMH services. The mission of YAAC is to advise BCMH of issues facing youth as they transition into adult medical and social services; and the Futures Committee who addresses and advises BCMH on issues, policies and procedures that impact the care provided to CSHCN by the local health departments.

Bureau of Child and Family Health Services (BCFHS) is designed as an organized community effort to improve the health status of women and children in Ohio by identifying needs and implementing programs and services to address identified needs. BCFHS goals are accomplished by engaging in a focused, multidisciplinary, collaborative approach to health improvement in coordination with internal and external stakeholder that serve racial and ethnic groups disproportionately affected by poor health outcomes, including but not limited to, local public health agencies, community health centers, community-based organizations, faith-based organizations, Regional Perinatal Centers, private sector organizations and other public health providers. Programs/initiatives include; Title X Family Planning (FP), infant mortality reduction (including a statewide task force to address infant mortality and disparities), lead poisoning prevention, prenatal tobacco cessation, Save Our Sight Vision Programs, Child Fatality Review and Sudden Infant Death Program. BCFHS receives funds through US EPA to provide environmental risk assessment screening services to women of reproductive age, to include Shaken Baby Syndrome Education Program, College Pregnancy and Parenting Offices Pilot Program, Neonatal Outcomes Improvement Project.

BCFHS also contracts with Cynthia Shellhaas, M.D., MPH to provide medical consultation to BCFHS programs serving reproductive age/pregnant women/children/families. Dr. Shellhaas is a licensed OB/GYN specializing in maternal-fetal medicine (high risk obstetrics) and holds a full-time faculty position in the Ohio State University's department of OB/GYN.

Bureau of Early Intervention Services (BEIS) the mission of the Bureau of Early Intervention Services is to assure early identification, support and intervention services for young children and families who have or are at risk for developmental delays or disabilities. Assure education and support to families, service providers/personnel and the general public, through evaluation,

planning and implementation statewide. BEIS is responsible for the administration of several programs serving young children (primarily birth to 3) and their families: The Help Me Grow program, Universal Newborn Hearing Screening (UNHS) and Infant Hearing Program: [Statutory Authority: 3701.508] OAC 3701-40 requires that every newborn be screened for hearing loss before hospital discharge, the Healthy Child Care Ohio project which provides for health/safety consultation by registered nurses to child care providers; and the Early Childhood Comprehensive Systems project which requires states to develop intersystem coordination of issues related to early care/education, family support/parenting education/medical home, and social/ emotional development of children birth to age 6.

Bureau of Community Health Services (BCHS) works towards providing information, technical assistance, funding and other support to a variety of local partners, that include local health departments, federally qualified health centers (FQHCs), non-dental health care professionals, schools, Early Start/Head Start programs, hospitals, private non-profit agencies and other safety net dental care providers, to improve access to culturally competent health care for Ohio's most vulnerable populations. Programs include; Community Water Fluoridation (community education and consultation), School-based dental sealant programs, a significant source of grants to safety net dental clinics improves access to dental health care through the OPTIONS Program (Ohio Partnership to Improve Oral Health through access to Needed Services). The program links uninsured/low income patients with safety net dental programs, or a network of dentists who agree to either donate or significantly discount their fees.

Additional sections in BCHS are: Primary Care and Rural Health programs, and School and Adolescent Health. BCHS also contributes content expertise in the area of Medicaid and emergency preparedness planning efforts to meet the needs of populations served by safety net health providers. BCHS is responsible for several major programs; the Primary Care Office (PCO) funded by a cooperative agreement with the HRSA, works to identify unmet needs for primary care by assisting communities in acquiring designation as federal Health Professional Shortage Areas and Medically Underserved Areas/Populations. The School and Adolescent Health (SAH) section promotes the health and safety of the school-aged and adolescent populations in Ohio through data collection, resource development, technical assistance, and training of approximately 1200 school nurses through regional continuing education and professional development opportunities throughout Ohio. Primary Care/Rural Health Program (PC/RH) provides funding for primary care services for uninsured populations of children/pregnant women, places health care providers via 7 placement programs in underserved areas. As of May 2010, Ohio has 140 health providers participating in state or federal loan repayment/scholarship programs (79 primary care, 33 mental health, and 28 oral health). There are 96 Federal National Health Service Corps and 44 State administered loan repayment programs. The recent federal health reform legislation greatly expanded the capacity of FQHCs as well as increased funding for the National Health Service Corps to address health care provider shortages. BCHS also manages the Black Lung Disease Program.

Bureau of Nutrition Services (BNS) responsible for administration of the USDA funded Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), as well as a Farmer's Market Nutrition program. The Ohio WIC program provides highly nutritious foods, breastfeeding education and support, immunization screening, health care referrals through local agencies to eligible individuals. WIC helps income-eligible pregnant/postpartum/breastfeeding women/infants/children who are at special risk with respect to physical and mental health due to inadequate nutrition, health care, or both. WIC works collaboratively on Title V initiatives for improving the health status of pregnant and breastfeeding women, infants/young children.

Title V Support in the ODH Office of Healthy OhioThe Office of Healthy Ohio is led by Deputy Director Nan Migliozzi, a key component of Governor Strickland's comprehensive health care reform initiative. The Healthy Ohio goal is to improve the health of all Ohioans to create a better quality of life, assure a more productive workforce and equip students for learning, while also contributing to the more efficient and cost-effective use of medical services. Within the Office of

Healthy Ohio is the Bureau of Infection Control, the Immunization Unit, the Injury Prevention Program, the Bureau of Health Promotion, Risk Reduction serves as lead for injury programming, the ODH Laboratory, responsible for Newborn Metabolic Screening and follow up, and the Bureau of Health Promotion/Risk Reduction is part of the Office of Healthy Ohio. The Healthy Ohio's Women's Health Program (WHP) receives MCH BG funding for 3 part time staff positions and various women's health activities. The Title V program coordinates with the areas described above to implement MCH BG strategies related to immunization, deaths due to motor vehicle crashes, and women's health issues, including domestic violence activities. The Title V program coordinates activities with the Office of Healthy Ohio related to primary/secondary prevention of chronic diseases (e.g., asthma, diabetes, heart disease) in school settings. A joint collaborative of Prevention and MCH was formed to become the Childhood Obesity Committee. School nurses have access to the Office of Healthy Ohio immunization registry/associated training to prevent school absence due to immunization non-compliance. Over the last year the MCH funded work of school nursing/school health collaborated with Healthy Ohio in planning educational training and materials for Asthma/Diabetes/Pandemic Flu.

The Office of Performance Improvement oversees the Center for Public Health Statistics and Informatics (CPHSI) is a centralized area responsible for the collection, analysis, dissemination and use of health data and provides support to MCH programs, Needs Assessment and the MCH BG. CPHSI allows MCH programs to easily access and integrate volumes of data and information for use in effective decision making. The State System Development Initiative (SSDI) and Pregnancy Risk Assessment Monitoring System (PRAMS) are administered by CPHSI.

The State Epidemiology Office (SEO) uses epidemiology to protect and optimize the health of Ohioans by guiding epidemiologic priorities and activities for the state; coordinating and collaborating with local, state and federal partners; building epidemiologic capacity; and assisting with the translation and reporting of epidemiologic findings and the application of those findings to public health programs and policies in Ohio. It is composed of a state epidemiologist, and senior state epidemiologists for MCH, chronic disease, infectious disease, and environmental health as well as interns and fellows. It supports Title V priorities directly through data analyses, reports, presentations and indirectly through MCH epidemiology strategic planning and capacity building and coordination efforts with other program areas. The state MCH epidemiologist has successfully recruited fellows and interns to address Title V priorities and has engaged CDC EIS officers in MCH work.

An attachment is included in this section.

D. Other MCH Capacity

Over 200 positions within ODH are either fully or partially supported by the MCH Block Grant (MCH BG); 179 are currently filled. Seventeen of these positions are housed in ODH District Offices; 162 are Central Office positions, based in Columbus.

Division of Family and Community Health Services
Karen F. Hughes
Division Chief
Education: B.S. Education; R.D.H.; M.P.H.
Experience: 15 years BCFHS Chief. Division Chief since February 2006.
Duties: Establish policy, standards and guidelines for the MCH programs and staff; directs the development of program budgets and resource allocations; reviews legislation impacting the MCH program and population served; integrates MCH program objectives with other ODH programs and State agencies; manages the daily operation of the Division. Works with private and public agencies to implement and improve science in children's health programs through BEACON Council (e.g., Ohio Perinatal Quality Collaborative, Solutions for Patient Safety in Children's Hospitals). Also collaborates with outside partners such as March of Dimes and

AMCHP to increase efficiencies and improve services.

Bureau for Children with Medical Handicaps
Karen F. Hughes
Interim, Bureau Chief
Education: B.S. Education; R.D.H.; M.P.H.
Experience: 15 years BCFHS Chief. Division Chief since February 2006.
With the retirement of Dr. James Bryant on July 30, 2010, Karen Hughes has assumes responsibility for this Bureau until a replacement for Dr. Bryant can be hired.
Duties: Develop standards, implement programs and direct the CSHCN program; supervise state CSHCN personnel; serve on appropriate boards and advisory groups including Ohio Developmental Disabilities Planning Council; serve on state and federal committees dealing with CSHCN issues. Chair of ODH IRB committee.

The BCMH employs a Parent Advocate, Kathy Bachmann, who works closely with the BCMH Parent Advisory Council and is involved in all Bureau decision making. Ms Bachmann works as a liaison, between families, the Parent Advisory Committee (PAC), Young Adult Advisory Committee (YAAC), and BCMH, providing programming information to families, and brings the family perspective to BCMH Program leadership. BCMH has developed regional youth advisory councils which advise the Bureau on how to address the transition from youth to young adult. In addition, the BEIS provides funding through Part C of IDEA to establish family support activities within the Help Me Grow (Birth to Three Program).

Division of Family and Community Health Services
Sue A Wolfe
Assistant Division Chief
Education: B.S. in Education; RDH; MA Public Administration
Experience: 10 years in Human Resources/Labor Relations/Workforce Development; 10 years in direct service and supervision in health related programs.
Duties: Coordinates projects that span across bureaus and assists programs in the initiation of policies and procedures to ensure the consistent development and implementation of MCH programs across the division. Directs the development of division responses to special assignments, correspondence, and administrative/policy issues. Participates in interagency work to coordinate MCH with other state services. Develops budgets, oversees development of state and federal grant applications for continuation programs and new initiatives consistent with Division and Departmental priorities.

Theresa Seagraves is the Maternal Child Health (MCH) Block Grant (BG) and Quality Improvement Coordinator, and serves as the data contact for all MCH BG issues and reports to the DFCHS Assistant Chief. With the retirement of Ruth Schrock in June of 2009, Ms. Seagraves came to the Ohio Department of Health on April 12, 2010 with over 20 years experience working in the health/mental health-care arena with a background in social work. Ms. Seagraves' primary responsibilities evolve around the development of statewide policies and procedures regarding the collection, analysis, and reporting of maternal, child and infant health data within the Division of Family and Child Health Services (DFCHS). Additional duties include coordinating the MCH BG application and Needs Assessment, and assisting with the integration of program activities among the State Epidemiology Office (SEO) and the Center for Public Health Statistics and Informatics (CPHSI).

Elizabeth Conrey, Ph.D., was assigned to the ODH by the Center for Disease Control (CDC) and Prevention, Division of Reproductive Health's Maternal and Child Health Epidemiology program. Dr. Conrey is a registered dietitian with a doctorate in community nutrition and an epidemiology minor from Cornell University. As a CDC assignee to the ODH, Dr. Conrey serves as the state's MCH Epidemiologist. Her duties revolve around capacity building in ODH MCH epidemiological studies. The State Epidemiology Office reports to the ODH Assistant Director for Programs. The office includes a senior-level core epidemiology team that meets federal recommendations

specifically from the Centers for Disease Control and Prevention [CDC] and the Council for State and Territorial Epidemiologists [CSTE]. This structure optimizes organizational synergy by encouraging better coordination of epidemiologic activities across the agency and across the state. Elizabeth Conrey, ODH's MCH Epi (CDC Assignee) was included in the State Epidemiology Office and was named the Deputy State Epidemiologist for MCH.

Under the State System Development Initiative Grant (SSDI) ODH has been successful in maintaining data sharing agreements with the Ohio Medicaid agency and the Ohio Hospital Association (OHA) and a number of MCH analyses have been completed using these data sources. This initiative is currently being managed by Bill Ramsini, SSDI Project Coordinator. ODH is awaiting approval to transfer those responsibilities to Connie Geidenberger, Ph.D., Chief, Maternal and Child Health Epidemiology due to Mr. Ramsini's retirement in August.

Bureau of Child and Family Health Services
Jo Bouchard, Bureau Chief
Education: B.S. Health Care Mgmt., R.D.H., M.P.H.
Experience: 25 years public health experience, including 4 years Chief; 4 years Assistant Chief; 6 years as Health Planning Administrator, BCFHS; 10 years in program administrator supervisory positions in Bureau of Oral Health Services; 1 year dental public health, Greene Co. Combined Health District.
Duties: Formulates and directs implementation of policies, procedures, goals and objectives for multiple MCH statewide programs in BCFHS. Programs include: Child and Family Health Services; Family Planning; Women's Health Services; Ohio Infant Mortality Reduction Initiative; Prenatal Smoking Cessation; Regional Perinatal Centers Program; Infant Mortality Consortium; Ohio Childhood Lead Poisoning Prevention; Save Our Sight; Pediatric Specialty Medical Clinics (Hearing, Vision); Child Fatality Review; Sudden Infant Death (SID); Shaken Baby Syndrome Education; Pregnancy Associated Mortality Review; Gestational Diabetes Mellitus and Chronic Disease Integration; Acts as Demobilization Unit Leader in Ohio Incident Command System.

Bureau of Community Health Services
Mark Siegal
Bureau Chief
Education: D.D.S.; M.P.H.; Certificate in Pediatric Dentistry; Certificate in Dental Public Health; Diplomat of the American Board of Dental Public Health and a past-president of the Ohio Academy of Pediatric Dentistry.
Experience: 23 years Chief; 2 years Columbus City Health Department Dental Director; 4 years Hospital Director for Pediatric Dental Services; 4 years New Mexico Health District Dental Director.
Duties: Directs the Bureau of Community Health Services activities toward improving the oral health of Ohioans by assessing needs, implementing community-based disease prevention and health promotion and increasing access to dental care. Maintains a liaison role with professional associations and other agencies on policy development and other collaborative efforts. Acts as a Planning Section Chief in the Ohio Incident Command System. Directs the assessment, planning, implementation, policy development and evaluation of statewide programs including the offices of Primary Care and Rural Health (including 6 health care provider recruitment and retention programs), Black Lung, School and Adolescent Health Services, and collaborative initiatives to improve health care access for underserved populations.

Bureau of Early Intervention Services
Sondra Crayton
Acting Bureau Chief
Education: BA, History, MA, Political Science, MA, Psychology, PhD, Psychology
Experience: 9 months, Acting Bureau Chief, 5.5 years experience as Assistant Bureau Chief, 6 years experience as Operations Manager at a local Family & Children First Council, 8 years as Adjunct Professor at The Ohio State University's School of Social Work
Duties: Directs the planning, development, implementation and evaluation of Bureau programs

which focus on families with infants and toddlers (Help Me Grow program including Part C IDEA and Home Visiting services for at risk infants and toddlers; Infant Hearing Screening program; and Healthy Child Care Ohio program); and coordinating interagency efforts around a state plan for Early Childhood systems which address medical home, family support, parent education and social-emotional development of young children.

Bureau of Nutrition Services
Michele A. Frizzell
Bureau Chief
Education: BS in Dietetics; Registered Dietitian; Master in Business Administration
Effective April 4, 2005, Michele Frizzell is Chief of the Bureau of Nutrition Services. Experience: Over 25 years of diverse public service experience, most recently at the Ohio Department of Alcohol and Drug Addiction Services (ODADAS), where she managed the quality improvement initiatives for a number of ODADAS statewide programs. For the ten years prior to her work at ODADAS, she held a number of positions in the ODH WIC Program, including program consultant, administrator of program support, and system redesign project manager.

E. State Agency Coordination

The Ohio Title V Program, administered within the ODH, has strong collaborative relationships with other state agencies, local health departments (LHD), local public heath agencies, academic programs/professional associations to improve the health of the MCH and CSHCN population.

Executive Level State Collaboration
Ohio Family and Children First (OFCF): OFCF is a collaborative effort of the state's education, health, and social service systems with Ohio families, concentrated on achieving the shared policy goal of ensuring that all children are safe, healthy and ready to learn. The partnership is critical because no single state system has the resources or capacity to meet this goal alone. Oversight of the initiative is provided by the OFCF Cabinet Council which include agency directors of; Ohio Department of Education (ODE), Ohio Department of Alcohol and Drug Addiction Services (ODADAS), Office of Budget Management (OBM), Ohio Department of Health (ODH), Ohio Department of Jobs and Family Services (ODJFS), Ohio Department of Mental Health (ODMH), Ohio Department of Developmental Disabilities (DODD), ODA, and Ohio Department of Youth Services (ODYS). The DFCHS Chief serves on the OFCF Deputies Committee to ensure a system-wide implementation of all OFCF priorities and activities. DFCHS data staff serves on the OFCF Data Committee to develop a set of child well-being indicators. Each of Ohio's 88 counties has created an OFCF Council,council membership includes families, representatives of public agencies, schools, courts and private providers. Each council is responsible for determining local strategies to achieve school readiness and address a shared commitment to child well-being which include.

BEACON
Ohio's Medicaid leadership has joined with the Ohio's Title V MCH Program to convene children's health care partners to form the BEACON Council. The aim of the Best Evidence for Advancing Childhealth in Ohio NOW (BEACON) initiative is to achieve transformational change in health outcomes for children by improving the quality of their healthcare. Through the systematic and reliable application of established improvement science methods and by building strong partnerships with key stakeholders, Ohio's statewide collaboration will achieve unprecedented results for birth and developmental/behavioral health outcomes and safe hospital care for children. Simultaneously, BEACON will establish a sustainable infrastructure for improvement capability.

In 2009 Governor Ted Strickland requested that the ODH establish a task force to study and report on infant mortality and disparities. A group of about 70 individuals made up the task force,

co-chaired by Thomas G. Breitenback, CEO of Premier Health Partners, Inc., and ODH Director Alvin D. Jackson, MD. Membership represented a wide range of public and private health providers, businesses, government agencies, associations, faith-based organizations, advocacy groups and consumers from across the state. In November 2009, the Ohio Infant Mortality Task Force issued its final report which provided extensive background information and included ten recommendations. The complete task force report, including involved organizations is available at http://www.odh.ohio.gov/odhPrograms/cfhs/imtf/imtf.aspx
The task force recommended the creation of an ongoing consortium to continue its work, and the ODH BCFHS is facilitating the development of this consortium. A small executive/steering committee is now being formed to develop the leadership and committee structure as well as bylaws. Later, members will be recruited for specialized committees. Once organized, the yet-to-be-named consortium will likely create a plan to promote implementation of the recommendations, search for funding, and prepare annual progress reports for the Governor.

The DFCHS Chief and BCFHS Chief serve on the Executive Council of the Cleveland Healthy Family/Healthy Start federal project to reduce infant mortality and have been actively involved with this project throughout its history. Both also serve on the Executive Council of the Columbus Healthy Start Project and participated in developing the coordination proposal submitted to MCHB.

The Primary Care/Rural Health (PCRH) program has taken the lead for 2 Presidential Initiatives in Ohio: development/expansion of FQHCs, and growth of the National Health Service Corps (NHSC). A coordinated effort is underway with Ohio Association of Community Health Centers (OACHC) to develop FQHCs in medically underserved areas. NHSC Scholarship and Loan Repayment Programs assist in staffing Ohio FQHCs as well as other safety net provider sites located in underserved areas. Ohio Rural Development Partnership (ORDP) developed a 501c3 organization, Ohio Rural Partners (ORP), which is able to apply for and receive federal/foundation/other funding. With the passage of the current biennial budget in July 2009, the administration of the OPDP Advisory Committee was transferred successfully from the Ohio Board of Regents to ODH. The BCMH Chief is the governor's appointed representative of ODH and Chair on the Ohio Physician Loan Repayment advisory committee which selects applicants who are practicing in underserved parts of Ohio to receive loan repayments funded with money collected with medical license renewals.

ODJFS develops and oversees programs that provide health care, employment and economic assistance, child support, and services to families and children, and administers the Medicaid program. ODH's Title V program has the following MCH/CSHCN-related interagency agreements with ODJFS: 1) Title V and Title XIX links services for the purpose of coordinating health services, conducting outreach, program eligibility and payment for services for mothers and children as defined and specified in 42 USC section 701, et. al., and 7 CFR Part 246. The agreement coordinates the exchange of information and referral among the local Child and Family Health Services projects (CFHS), WIC, Help Me Grow (HMG), Ryan White programs, Offices of Primary Care and Rural Health (PCRH), and the Ohio Medicaid programs, 2) environmental lead risk assessment done in homes of Medicaid-eligible children with blood lead levels (BBL) > or equal to 10 ug/dL; 3) agreement reimbursing ODH for costs associated with the development of brochures/materials, and training on communicable diseases/first aid/medicationadministration/back-to-sleep/developmental screening/inclusive child care as part of a health/safety training curriculum for child care providers/ trainers, 4) a statewide immunization and MMIS interface creates interface between ODJFS & ODH to share immunization records and sharing of blood lead screening on Medicaid-eligible children & other lead related information. This agreement will provide Medicaid funds for development of a new lead poisoning surveillance system, 5) agreement between ODJFS and ODH for the conduct of desk reviews/interim settlements/field audits/and final settlements for ODH's BCMH. The agreement meets the requirements of Title V for financial accountability and administration of BCMH, 6) inter-agency agreement provides funding for an annual training session required for members of Child Fatality Review Boards (CFR). BCFHS coordinates with the ODJFS Children's

Trust Fund Board on activities related to the CFR program; 7) data sharing and research projects of mutual interest related to the administration of Medicaid and the State Children's Health Insurance Program produced information needed for MCH policy decisions.

ODH and ODJFS work together to assist in implementation/coordination of the Ohio mandated Medicaid Managed Care Program. ODH worked with ODJFS Medicaid and Managed Care Plan personnel to implement managed care contracts between the plans/health agencies.

ODJFS participates with ODH Perinatal Data Use Consortium. ODH entered into an interagency agreement with ODJFS to provide support to the Ohio Perinatal Quality Collaborative (OPQC). Most support is provided by the Regional Perinatal Center Program facilitating local access for quality improvement initiatives. ODH in collaboration with ODJFS are addressing poor pregnancy outcomes through a CMS sponsored transformation effort involving a partnership of state agencies, neonatal/obstetrical providers, professional organizations and a center with expertise in quality improvement. This effort has already demonstrated substantial improvements in perinatal outcomes. OPQC's first obstetrics project achieved a statistically significant 70% reduction (12.5% to 4%) in the rate of scheduled late preterm deliveries without medical indication, and a reduction in NICU-associated, bacterial, bloodstream ifnrect8ins in preterm infants 22-29 weeks gestational age by 40% (20% to 12%)

An agreement between the Social Security Administration (SSA) and ODH establishes conditions under which SSA agrees to disclose information related to eligibility for and payment of Social Security benefits and/or supplemental security income and special veterans benefits, including certain tax return information to ODH for use in verifying income/eligibility.

An interagency steering committee (including parents, private organizations, and nine state agencies) co-chaired by ODADAS, ODH, and DODD, guides the Ohio Fetal Alcohol Spectrum Disorders (FASD) initiative through components including primary/secondary prevention services, education and regional parent networking. The charge to the steering committee is to integrate FASD activities in state/local agencies through existing programs/systems, not relying on dedicated funding. Through the partnership, a state website was launched, www.notasingledrop.org which provides information about FASD to health care professionals, families and the general public. The steering committee has partnered, with the Ohio Center for Autism and Low Incidence (OCALI) to promote FASD education and FASD is a featured topic on the OCALI website at: http://www.ocali.org The state's FASD initiative continues to work to prevent alcohol-exposed pregnancies and improve screening, diagnosis and services referrals for those affected by prenatal alcohol exposure.

The DFCHS Chief serves on the ODJFS Children's Trust Fund Board; ODH coordinates with the Trust Fund on activities related to the CFR program, including preparation and publishing of the CFR annual state report.

ODE receives TA and training by DFCHS nutrition/oral health/ nursing/hearing/vision consultants to state Head Start Programs in collaboration with Ohio Head Start Association, Inc. (OHSAI) and ODE. At the request of OHSAI and ODE, Division of Early Childhood Education, a state Head Start/WIC agreement designed to promote collaboration between the 2 programs in the areas of nutrition screening, assessment, education, referral, and recruitment was signed.

Specific Bureau Related Collaboration
Bureau of Early Intervention Services (BEIS) collaborates with the ODJFS Bureau of Child Care and the Child Care Resource and Referral Association to expand the network of child care health consultants (RNs) to provide health/safety information to licensed child care providers. The ODH Healthy Child Care Ohio coordinator serves as an ex-offico member on the ODJFS Day Care Advisory Council, a legislatively mandated body that advises ODJFS on child care policy and implementation of child care law. The HMG program in BEIS collaborates with the Part B Special Education and 619 (Preschool programs at ODE to assure that training and information to local

programs and school districts are coordinated where necessary. There is an agreement between ODH and DODD to assist DODD staff that provide TA to local county boards concerning Help Me Grow.

An agreement between ODH and DODD confirms their intent to assist jointly in comprehensive planning/coordination for a statewide HMG system to include infants/toddlers with developmental delays/disabilities, as defined in Part C of the Individuals with Disabilities Act, and their families. DFCHS staff serves on several interagency committees including the Ohio Autism Taskforce which was staffed by DODD.

Collaboration with ODMH happens on 2 levels; BEIS is working closely with the early childhood mental health initiative (MHI) at ODMH on projects addressing early identification and referral of new mothers with postpartum depression and young children with potential social/emotional needs; and training providers on ways to work with families with young children with challenging behavior, training is provided by ODMH. BCHS continues to work on school based MHIs by representing the school nurse perspective and has co-sponsored a statewide strategic planning session to develop a plan for increasing school based mental health programs in Ohio schools. Currently there are 4 pilot programs in 4 area school districts using the "Columbia Teen Screen"/Depression Screening Program.

Bureau of Community Health Services (BCHS) provides TA to approximately 1,200 school nurses as they assist families/students to access primary care/mental health/ dental health safety net services identified by the Primary Care Program to address unmet health care needs and to eliminate health disparities.

BCHS School and Adolescent Health (SAH) program helps ODE improve nutrition messages for school aged children/families/teachers with the expertise of a public health nutritionist funded by the MCH BG. The SAH program works with randomly selected local school districts to administer the YRBS. In collaboration with the Ohio Chapter of the American Cancer Society, SAH administers the Governor's Buckeye Best School awards program which recognizes schools for achievements in the areas of increasing physical activity, improving nutrition and preventing tobacco use. The school nursing supervisor in SAH worked collaboratively with ODE special education services to revise rules for providing clinical services to students with special health care needs. SAH collaborated with ODE to write a grant application to CDC that funds support for YRBS, Coordinated School Health and HIV education. The SAH is working with the ODE on implementing the CDC Coordinated School Health (CSH) grant. The CSH grant has resulted in an MOU with ODE which funds one full time equivalent (FTE) to function as the project coordinator for ODH. SAH is providing technical assistance and training to school districts and ODH funded agencies promoting school health using the CSH framework. The SAH program works collaboratively to promote school healthy with the Ohio School Based Health Center Association and Ohio Action for Healthy Children by participating on the Board of Directors of both agencies.

PCRH staff collaborated with the State Refugee Coordinator at ODJFS to submit a Refugee Preventive Health grant application to provide infrastructure building and enabling services to improve health screening and medical follow up within 90 days of refugees' arrival in the US.

Bureau of Nutrition Services (BNS) continues coordination with the Ohio Department of Rehabilitation and Correction (ODRC) for the Prison Nursery Program. BNS continues its coordination with the Ohio Environmental Protection Agency (OEPA) for the annual Sport Fish Consumption Advisory. BCHS works with OEPA to maintain current information on the fluoride status of community water systems. Ohio EPA continues to participate on the Ohio Lead Advisory Council.

ODE sits on the ODH Lead Advisory Council, which is adding requirements for child care's school facilities to ensure lead safe environments.

An ODH representative from the OCLPPP serves as an appointed steering committee member of the Greater Cleveland Lead Advisory Council.

Other Professional and Medical Collaboration
The ODH Title V Program works closely with related professional medical organizations through staff participation on numerous advisory boards/committees, and shares some committees with organizations.

Ohio Hospital Association (OHA): OHA is the membership/advocacy organization for Ohio's hospitals. OHA has developed a strong interest in its small/and rural hospitals, and has created a Small/ Rural Hospital Committee. In addition, OHA partnered with the State Office of Rural Health (SORH) in the development/implementation of the State Rural Hospital Flexibility Grant Program that enabled Ohio to designate Critical Access Hospitals (CAHs). Early in the development of this Program an advisory committee was created, with representation from OHA, the SORH, rural hospitals, the OACHC, the Ohio State Health Network, Division of EMS, ORDP, and others with an interest in strengthening the rural health infrastructure. The Flex Advisory Board meets quarterly; since its inception this meeting has been hosted by OHA. A total of 34 small rural hospitals have achieved CAH designation in Ohio. There is a memorandum of understanding for data sharing between ODH and OHA. ODH developed an agency agenda for data needed from OHA for research/reporting purposes and has received and analyzed OHA data. ODH staff is currently analyzing hospitalization data dealing with ambulatory sensitive conditions to determine potential access to care issues across Ohio.

Ohio Association of Children's Hospitals (OACH): BCMH collaborates closely with OACH. The Association is a key member of the MCH Advisory Counsel, the Birth Defects Advisory Council, and serves on other advisory groups as requested. OACH is a key partner/advocate for health care issues for all children, especially CSHCN.

Ohio Chapter/American Academy of Pediatrics (OC/AAP): OC/AAP shares the Children with Disabilities Subcommittee with the BCMH Medical Advisory Council. This subcommittee is made up of members from the private sector and several state agencies and deals with social/educational issues of CSHCN in addition to medical issues. The DFCHS participates with the OC/AAP in development of a long term strategic plan targeting mental health concerns for children/adolescents. The BCHS works with OC/AAP and American Council of Family Practitioners to develop oral health training for physicians/ pediatricians.

Ohio Section of ACOG: The DFCHS Chief attends Ohio ACOG quarterly meetings to share information from ODH. Ohio ACOG and other diverse groups are members of the Family Planning (FP) Advisory Council and the FP State-Wide Needs Assessment Stakeholders Workgroup.

Ohio Dental Association (ODA): BCHS partners with ODA to administer a statewide volunteer dental care program called Dental OPTIONS (Ohio Partnership To Improve Oral health through access to Needed Services). This dental referral/case management program matches clients with dentists who provide discounted or donated care in their offices.

Ohio Head Start Association, Inc. (OHSAI): BNS has an interagency agreement with OHSAI for the purpose of program coordination. BCHS collaborates closely with the OHSAI and convenes the Head Start Oral Health Steering Committee on a regular basis. Among other agencies/organizations on this group are ODJFS, ODH BEIS, State Head Start Collaboration Office, Ohio Academy of Pediatric Dentistry, ODA, and numerous local groups.

Health Policy Institute of Ohio (HPIO): BCHS collaborates with HPIO to convene the Dental Workforce Roundtable, with representatives from dental schools, organized dentistry, dental hygiene and dental expanded functions: state dental board, PCA, and Association of Ohio Health

Commissioners. BCHS is actively represented on Ohio Coalition for Oral Health, with LHDs, FQHCs, and OACHC.

Ohio Public Health Association (OPHA): BCHS assumed the lead to work with OPHA Directors of Nursing Section and Ohio Nurses Foundation (ONF) to develop 17 web based continuing education modules in support of public health nurse (PHN) workforce development. Eight of the modules were based on competencies developed by the Council on Linkages Between Academia and Public Health Practice. Five of the modules were designed for school nurses; 4 were designed to meet the learning needs of PHNs who supervise a new health care provider role in Ohio, Community Health Worker. All of the modules can be accessed at www.publichealthnurses.com. The OPHA Directors of Nursing section discussed using the 8 updated competency based modules as prerequisites for the quarterly PHN orientation content presented by ODH. All 17 modules will move to a website supported by the ONF.

Ohio Lead Advisory Council (OLAC): In addition to appointed members from ODJFS/ODE/OEPA, these organizations also have members who serve on the OLAC: Ohio Department of Development, Apartment Owner's Association, Help End Lead Poisoning Coalition, Environmental Health Association, National Paint and Coatings Association, and other nonprofit/public health agencies outside of the appointed membership.

ODH (BCFHS) will partner with the department of obstetrics and gynecology at The Ohio State University College of Medicine (OSU-COM), which has been named as a recipient of Agency for Healthcare Research and Quality funds, to develop a state-wide Pregnancy Associated Mortality Review (PAMR) system in Ohio. Pregnancy-associated mortality review (PAMR) is a perfect illustration of a process where a focus on patient safety and prevention of adverse events would lead to improvements in both healthcare system operations and clinical care. This would, in turn, decrease the potential for medical liability claims. Ohio is one of 5 states that will work with the National Universal Vision Screening for Young Children Coordinating Center.

This National Center will promote and ensure a continuum of eye care for young children within the healthcare system. Ohio Coalition member include the Ohio Departments of Education and Job and Family Services (Medicaid) as well as professional organizations such as the Ohio Chapter of the American Academy of Pediatrics, Ohio Academy of Family Physicians and National Association of Pediatric Nurse Practitioners. ODH is a co-chair of this Coalition and Karen Hughes is serving on the national advisory panel as the title V representative for this project.

F. Health Systems Capacity Indicators

Introduction

The Health System Capacity Indicators (HSCIs): Introduction - combined the HSCIs are an important set of indicators that act as a catalyst for working with health and social service systems beyond the Title V program. For many of these indicators, the State Systems Development Initiative (SSDI) Grant is the vehicle by which relations with other agencies/organizations e.g., Ohio Medicaid; Ohio Hospital Association, are formed and maintained so that data can be acquired, analyzed and used for further action.

ODH has made progress in many of the targeted areas. We were successful in maintaining the data sharing agreements with the Ohio Medicaid agency and the Ohio Hospital Association (OHA) and a number of analyses have been completed using these data sources. A new contract for the SSDI-funded statistical assistance was signed with the Ohio State University. The current contractor has provided statistical assistance in sampling design, and data weighting work in areas such as 7th, and 3rd grade BMI Surveys, Vision and Hearing Survey; Oral Health Surveys, YRBS Survey; and School Nurses Survey.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	33.2	41.7	36.0	34.7	35.2
Numerator	2428	2456	2117	2041	2072
Denominator	731672	588394	588368	588368	588368
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
The data associated with this indicator is retrieved from the Ohio Hospital Association.

Notes - 2008
Data received from OHA

Notes - 2007
Data source: Ohio Hospital Association (OHA) Statewide Clinical and Financial database, 2007.
Numerator: the number of hospital discharges for Ohio residents ages 1 through 4 years for 2007.
Denominator: 2007 U.S. Census population of Ohio children ages 1 through 4 years. Bridged-race Vintage 2005 postcensal population estimates for July 1, 2000 - July 1, 2007, by county, single-year of age, Hispanic origin, and sex

Narrative:
In the next year, the Ohio Childhood Lead Poisoning Prevention Program (OCLPPP) will transition to a Healthy Homes & Lead Program to reflect the change in focus at the national level, CDC's Healthy Homes and Lead Poisoning Prevention Branch. This new focus seeks to broaden the scope of single-issue public health programs, such as the childhood lead poisoning prevention and asthma programs, to address multiple housing deficiencies that affect health and safety. The primary concepts of a healthy home include keeping it dry, clean, safe, well-ventilated, pest-free, contaminant-free and well-maintained. For instance, by reducing mold and allergens in the home, we can improve the quality of life for children with asthma. The Ohio Healthy Homes and Lead Program will promote, develop, and implement cross-disciplinary activities at the state and local level to address the problem of unhealthy and unsafe housing through surveillance, and comprehensive prevention programs.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	80.4	81.5	80.5	78.0	81.4
Numerator	58184	61112	61815	62942	63482
Denominator	72334	74970	76800	80720	77953
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years					

is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data reflects SFY 2009 and Services. An infant could have been enrolled in both Medicaid (Title XIX & SCHIP (Title XXI) during the year and would be counted in both Measure #02 and Measure #03.

Notes - 2008
Data Source: Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid - Title XIX). Data reflects SFY 2008 80.6 percent of Medicaid enrollees under the age of one year (those born between July 1, 2 through June 30, 2008) received at least one periodic screen during the period July 1, 2007 - June 30, 2008.

Report produced by the Ohio Department of Health, Center for Public Health Statistics and Informatics.

Notes - 2007
Data Source: Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid - Title XIX). Data reflects SFY 2007 Medicaid enrollment and services. Denominator: The number of Medicaid enrollees whose age is less than one year.

Report produced by the Ohio Department of Health, Division of Family and Community Health Services.

Narrative:
Ohio Medicaid has initiated several recent efforts with the county agencies and the Medicaid Managed Care Plans to increase the number of children who receive their periodic well child visits. ODH has partnered with Ohio Medicaid on several activities including developmental and autism screenings as part of the visit. In SFY 2008, 78.8 percent of Medicaid enrollees under the age of one year received at least one initial periodic screen, down from 80.5 percent in SFY 2007. An infant could have been enrolled in both Medicaid (Title XIX) and SCHIP (Title XXI) during the year and would be counted in both Measures 02 and 03. SCHIP is run within Medicaid. Data source is the ODJFS, Ohio Health Plans (Medicaid). Data for this report were prepared by ODH, Center for PH Statistics & Informatics.

Explanatory note from ODJFS: Methodology for these measures has evolved over the years, and thus, comparisons to prior years can be problematic.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	64.8	67.0	64.6	55.5	70.4
Numerator	2696	2902	2676	4931	5268
Denominator	4162	4332	4143	8888	7484
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot					

be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data reflects SFY 2009 enrollment and Services. A recipient could have been enrolled in both Medicaid & SCHIP during the year and would be counted in both Measures #02 and Measure #03.

Notes - 2008
Data Source: Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid). Data reflects SFY 2008 SCHIP enrollment and services. A recipient could have been enrolled in both Medicad and SCHIP during the year and would be counted in both Measure 02 and Measure 03.

Report produced by the Ohio Department of Health, Center for Public Health Statistics and Informatics.

Notes - 2007
Data Source: Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid). Data reflects SFY 2007 SCHIP enrollment and services. Denominator: The number of SCHIP enrollees whose age is less than one year.

Report produced by the Ohio Department of Health, Division of Family and Community Health Services.

Narrative:
Ohio Medicaid has initiated several recent efforts with the county agencies and the Medicaid Managed Care Plans to increase the number of children who receive their periodic well child visits. ODH has partnered with Ohio Medicaid on several activities including developmental and autism screenings as part of the visit.

In SFY 2008, 55.5 percent of State Children's Health Insurance Program (SCHIP) enrollees under the age of one year received at least one periodic screen, down from 64.6 percent in 2007. An infant could have been enrolled in both Medicaid (Title XIX) and SCHIP (Title XXI) during the year and would be counted in both Measures 02 and 03. SCHIP is run within Medicaid. ODH will continue to work w/ODJFS to refine collection of data to enable de-duplicated counts for HSCI 02 and 03. Data source is the Ohio Department of Job and Family Services (ODJFS), Ohio Health Plans (Medicaid). Data for this report were prepared by ODH, Center for Public Health Statistics and Informatics.

Explanatory note from ODJFS: Methodology for these measures has evolved over the years, and thus, comparisons to prior years can be problematic.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	85.9	71.5	69.5	68.6	68.6
Numerator	111886	76985	78394	73819	73819
Denominator	130193	107631	112792	107642	107642
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The 2009 data is currently not available. 2008 data has been used as an estimate for 2009.

Notes - 2008
2007 data are not available. 2008 data are used as estimates for 2008

Notes - 2007
Data Source: Ohio Vital Statistics, 2007 final resident birth data, prenatal visits not missing.

Narrative:
Recognizing the unacceptable rates and disparities in infant mortality in Ohio, in early 2009, Gov. Ted Strickland asked the Ohio Department of Health (ODH) to establish the Ohio Infant Mortality Task Force (IMTF) to (1) take a fresh look at the reasons behind Ohio's overall infant mortality rate and increasing disparities among different populations; and (2) develop recommendations and strategies to prevent infant mortality and disparities. A group of about 70 individuals made up the task force, including public and private health providers (some nationally recognized experts in the field), businesses, government agencies, associations, faith-based organizations, advocacy groups and consumers from across the state. Many community, county, and state-led programs and initiatives in Ohio have focused on the issue of infant mortality over the past several decades. The IMTF surveyed both ongoing efforts as well as research being done in Ohio and will work synergistically with these entities to maintain and/or improve the infant mortality efforts in Ohio.

In 2009 Governor Ted Strickland requested that the ODH establish a task force to study and report on infant mortality and disparities. A group of about 70 individuals made up the task force, co-chaired by Thomas G. Breitenbach, CEO of Premier Health Partners, Inc., and ODH Director Alvin D. Jackson, MD. In November 2009, the Ohio Infant Mortality Task Force (IMTF) issued its final report which provided extensive background information and included ten recommendations. The report is available at http://www.odh.ohio.gov/odhPrograms/cfhs/imtf/imtf.aspx.

The IMTF recommended the creation of an ongoing consortium to continue its work, and the ODH BCFHS has recently convened this consortium. The charge of the consortium is to implement and monitor the recommendations set forth by the task force and approved by the governor. The consortium members are working through the following committee structure to provide statewide leadership and coordination of efforts to prevent infant mortality and improve the health of women of childbearing age and infants throughout Ohio: an Executive Committee and Workgroups including Coordinated health care throughout a woman's and child's life, Disparities and their underlying causes including racism, Data/Metrics/QI, Education/Outreach and Public Policy.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**

Annual Indicator	86.6	84.7	83.2	82.8	83.1
Numerator	1038301	988028	859076	867727	927610
Denominator	1198969	1166365	1031971	1047368	1116396
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Denominator: The number of children age 1 to 21 years of age who were enrolled in Medicaid (Title XIX) during SFY 2009. Does not include children potentially eligible for Mediciad but not actually enrolled.

Notes - 2008
Data Source: Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid - Title XIX). Data reflects SFY 2008 Medicaid enrollment and services. Does nclude SCHIP participants.
Denominator: The number of children age 1 to 21 years of age who were enrolled in Medicaid (Title XIX) during SFY 2008. Does not represent the number of children potentially eligible, but who are not enrolled in Medicaid. Does include SCHIP enrollees.

Calculations done at Ohio Department of Health, Center for Public Health Statistics and Informatics.

Notes - 2007
Data Source: Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid - Title XIX). Data reflects SFY 2007 Medicaid enrollment and services. Does not include SCHIP participants (198,921) Denominator: The number of children age 1 to 21 years of age who were enrolled in Medicaid (Title XIX) during SFY 2007. Does not represent the number of children potentially eligible, but who are not enrolled in Medicaid. Does not include SCHIP enrollees (208,067).

Calculations done at Ohio Department of Health, Division of Family and Community Health Services.

Narrative:
In State Fiscal Year 2008, 82.8 percent of Medicaid-eligible children received a service paid by the Medicaid program, compared to 83.2 percent in 2007. The data source is the Ohio Department of Job and Family Services, Medicaid program. Data for SFY 2008 were prepared by ODH, Center for Public Health Statistics and Informatics.

The 2006-2007 State budget more than doubled the size of Ohio's Medicaid program, from 529,000 enrollees in 15 counties in June 2005 to 1.3 million enrollees in all 88 counties in January 2009. In most counties, Medicaid managed care enrollees have a choice of three health plans. Statewide, seven health plans serve Medicaid beneficiaries. As a result of the managed care expansion, almost all Medicaid-eligible children and parents -- 1.2 million people as of January 2009 -- receive Medicaid services through a managed care organization. Each month, Medicaid covers: • 992,000 children (1 out of 3), including 34,000 children with disabilities.

Children's Buy-In (CBI) Program
CBI provides another option for Ohio's uninsured children in families with income above 300% of federal poverty guidelines ($63,600 annually for a family of four). CBI allows working families who

have uninsured children with special health needs or high monthly premiums to purchase public health coverage (Medicaid Healthy Start) for their children. Children must be uninsured for six months prior to enrolling and must meet additional criteria in order to qualify. The CBI program began April 2008 and, despite early estimates that 5,000 uninsured Ohio children would obtain coverage, only two children were enrolled in CBI as of November 2008.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	48.1	47.3	45.4	47.7	49.5
Numerator	110765	114182	101048	117878	128399
Denominator	230292	241412	222725	247133	259348
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data reflects SFY 2009 dates of service. The data includes Medicaid (Title XIX) and SCHIP (Title XXI) Recipients who were between 6 through 9 for the entire SFY 2009.

Notes - 2008
Data Source: Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid). Data reflects SFY 2008 dates of service. The data include Medicaid (Title XIX) and SCHIP (Title XXI) recipients who were between 6 through 9 at any time during SFY 2008. A recipient who participated in both programs during SFY 2009 would be counted in both.

Report produced by the Ohio Department of Health, Center for Public Health Statistics and Informatics.

Notes - 2007
Data Source: Ohio Department of Job and Family Services, Ohio Health Plans (Medicaid). Data reflects SFY 2007 dates of service. The data only includes Medicaid (Title XIX) recipients who were between 6 through 9 for the entire SFY 2007.

Report produced by the Ohio Department of Health, Division of Family and Community Health Services.

Narrative:
Ohio has experienced decreased state funding for subsidies to support dental safety nets, in response to state budget shortfalls, will result in fewer children ages 6-9 receiving dental services through these programs. It is unclear at this time how private practice dentists who provide care for Medicaid/SCHIP eligible children will respond to the current economic downturn during the next state fiscal year. Through a HRSA-funded workforce grant, ODH has been able to restore some of the budget cuts to the Dental Safety Net subgrant program.

However, funding was not fully restored and additional budget cuts may be looming in the future.

At the same time, a newly created grassroots group, the Children's Oral Health Action Team (COHAT) was created in FFY2010 to support and influence children's oral health awareness and policy. This broad-based advocacy group is developing strategies to impact children's access to Medicaid-covered oral health services through two approaches: 1) recommending Medicaid implement a code and fee for dental case management services and patient advocacy to improve the outcomes of dental visits for children and 2)awarding a pilot project contract to a commercial third party to administer the dental Medicaid program in a manner designed to increase provider participation and use of needed services by Medicaid/SCHIP recipients (similar to Michigan's Healthy Kids Dental Program).

These initiatives are in the early planning stages and will not have a significant impact on the utilization of Medicaid services by 6-9 year olds in FFY2011. If these strategies are successfully implemented during FFY2011, increases in Medicaid utilization by 6-9 year olds may be seen in the following year.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	39.4	31.6	43.9	3.5	3.5
Numerator	8919	9197	16218	1373	1373
Denominator	22648	29096	36942	38765	38765
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
The 2009 data is currently not available from our sister agency Ohio Department of Jobs and Family Services, we will finalize the data as soon as we receive verification from ODJFS.

Notes - 2008
The data used for 2008 is still provisional and is currently not available. We retrieve this information from our sister agency Ohio Department of Jobs and Family Services and they are currently unable to finalize the data. The numerator is the number of children on SSI referred to the BCMH program for services from the state SSI determination unit located in the Department of Rehabilitative Services.

Narrative:
The Ohio Department of Health (ODH), Bureau for Children with Medical Handicaps (BCMH) works with the Regional SSI office to determine numbers for this indicator.

BCMH is still unable to complete the data match with the local SSI data repository located at the Ohio Department of Job and Family Services (ODJFS). The individual who regularly performs data matches has been re-assigned and ODJFS has no one assigned to assist with this data request. The above number represents denominator - data from SSI Supplemental Security Record, state specific data.

The BCMH works with the Regional SSI office to determine the compliance with this indicator. BCMH encourages participants in its program to apply for SSI when appropriate. BCMH has had an aggressive public awareness campaign with 120 local health departments, to ensure that children with special health care needs are referred to SSI for evaluation of eligibility. Local Public health nurses employed by health departments provide service coordination activities on behalf of BCMH. The PHN also coordinates referral to SSI, Early Intervention, and WIC. In addition, BCMH has provided educational in-services, in partnership with local SSI staff, to 315 field nurse consultants and local public health nurses. BCMH provided copies of the Social Security and SSI Benefits for Children with Disabilities booklet to the local health department nurses who work with the BCMH program.

BCMH continues to work with ODJFS to secure the data, however there has been a signficant decrease in personnel at ODJFS. BCMH continues to identify children who obtain SSI and refer them to services. This is currently done manually.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	10.6	7.3	8.6

Notes - 2011
The Data Soucre is the Ohio Vital Statistics Birth and Mortality Records. Payer source is unknown for 4.2% of births.

Narrative:
Outcomes for persons who are on Medicaid are worse than the population as a whole, than those no on Medicaid.
Recognizing the unacceptable rates and disparities in infant mortality in Ohio, in early 2009, Gov. Ted Strickland asked the Ohio Department of Health (ODH) to establish the Ohio Infant Mortality Task Force (IMTF) to (1) take a fresh look at the reasons behind Ohio's overall infant mortality rate and increasing disparities among different populations; and (2) develop recommendations and strategies to prevent infant mortality and disparities. A group of about 70 individuals made up the task force, including public and private health providers (some nationally recognized experts in the field), businesses, government agencies, associations, faith-based organizations, advocacy groups and consumers from across the state. Many community, county, and state-led programs and initiatives in Ohio have focused on the issue of infant mortality over the past several decades. The IMTF surveyed both ongoing efforts as well as research being done in Ohio and will work synergistically with these entities to maintain and/or improve the infant mortality efforts in Ohio.

In 2009 Governor Ted Strickland requested that the ODH establish a task force to study and report on infant mortality and disparities. A group of about 70 individuals made up the task force, co-chaired by Thomas G. Breitenbach, CEO of Premier Health Partners, Inc., and ODH Director Alvin D. Jackson, MD. In November 2009, the Ohio Infant Mortality Task Force (IMTF) issued its final report which provided extensive background information and included ten recommendations. The report is available at http://www.odh.ohio.gov/odhPrograms/cfhs/imtf/imtf.aspx. The IMTF recommended the creation of an ongoing consortium to continue its work, and the ODH BCFHS has recently convened this consortium. The charge of the consortium is to implement and monitor

the recommendations set forth by the task force and approved by the governor. The consortium members are working through the following committee structure to provide statewide leadership and coordination of efforts to prevent infant mortality and improve the health of women of childbearing age and infants throughout Ohio: an Executive Committee and Workgroups including Coordinated health care throughout a woman's and child's life, Disparities and their underlying causes including racism, Data/Metrics/QI, Education/Outreach and Public Policy.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	matching data files	9.5	7.4	8.3

Notes - 2011
The most current data for this measure are for CY 2008. (Data were prepared by the ODH Center for Public Health Statistics and Informatics). Data presented are adjusted infant mortality rates, which assign any unmatched infant death certificates to Medicaid and non-Medicaid deaths on the basis of each group's proportion of matched live births.

Narrative:
Outcomes for persons who are on Medicaid are worse than the population as a whole and those not on Medicaid. The death rate among infants on Medicaid was 22.1 percent higher than the death rate of those who were not on Medicaid.
Recognizing the unacceptable rates and disparities in infant mortality in Ohio, in early 2009, Gov. Ted Strickland asked the Ohio Department of Health (ODH) to establish the Ohio Infant Mortality Task Force (IMTF) to (1) take a fresh look at the reasons behind Ohio's overall infant mortality rate and increasing disparities among different populations; and (2) develop recommendations and strategies to prevent infant mortality and disparities. A group of about 70 individuals made up the task force, including public and private health providers (some nationally recognized experts in the field), businesses, government agencies, associations, faith-based organizations, advocacy groups and consumers from across the state. Many community, county, and state-led programs and initiatives in Ohio have focused on the issue of infant mortality over the past several decades. The IMTF surveyed both ongoing efforts as well as research being done in Ohio and will work synergistically with these entities to maintain and/or improve the infant mortality efforts in Ohio.

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underlying causes including racism, Data/Metrics/QI, Education/Outreach and Public Policy.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	payment source from birth certificate	59	76.4	69.7

Notes - 2011
The Data Source is the Ohio Vital Statistics Birth and Mortality Records. Payer source is unknown for 4.2% of births.

Narrative:
Persons who are on Medicaid are less likely to receive timely prenatal care compared to those who are not.
Recognizing the unacceptable rates and disparities in infant mortality in Ohio, in early 2009, Gov. Ted Strickland asked the Ohio Department of Health (ODH) to establish the Ohio Infant Mortality Task Force (IMTF) to (1) take a fresh look at the reasons behind Ohio's overall infant mortality rate and increasing disparities among different populations; and (2) develop recommendations and strategies to prevent infant mortality and disparities. A group of about 70 individuals made up the task force, including public and private health providers (some nationally recognized experts in the field), businesses, government agencies, associations, faith-based organizations, advocacy groups and consumers from across the state. Many community, county, and state-led programs and initiatives in Ohio have focused on the issue of infant mortality over the past several decades. The IMTF surveyed both ongoing efforts as well as research being done in Ohio and will work synergistically with these entities to maintain and/or improve the infant mortality efforts in Ohio.

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Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	payment source from birth certificate	61.8	72.8	68.6

Notes - 2011
The Data Source is the Ohio Vital Statistics Birth and Mortality Records. Payer Source is unknown for 4.2% of births.

Narrative:
Persons who are on Medicaid are less likely to receive adequate prenatal care compared with those who are not.
Recognizing the unacceptable rates and disparities in infant mortality in Ohio, in early 2009, Gov. Ted Strickland asked the Ohio Department of Health (ODH) to establish the Ohio Infant Mortality Task Force (IMTF) to (1) take a fresh look at the reasons behind Ohio's overall infant mortality rate and increasing disparities among different populations; and (2) develop recommendations and strategies to prevent infant mortality and disparities. A group of about 70 individuals made up the task force, including public and private health providers (some nationally recognized experts in the field), businesses, government agencies, associations, faith-based organizations, advocacy groups and consumers from across the state. Many community, county, and state-led programs and initiatives in Ohio have focused on the issue of infant mortality over the past several decades. The IMTF surveyed both ongoing efforts as well as research being done in Ohio and will work synergistically with these entities to maintain and/or improve the infant mortality efforts in Ohio.

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Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2009	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	200

Notes - 2011
Verfication with ODJFS the percentages remain 150.

Narrative:
The Ohio Department of Job and Family Services, Medicaid Program, provides information on the poverty level for eligibility in the State's Medicaid and SCHIP Programs.

Ohio Medicaid covered 2.2 million Ohioans in 2008 (total annual non-duplicated enrollment). However, because people enter and exit the program throughout the year, Medicaid covered, on average, 1.7 million Ohioans each month. Some low-income areas of the state depend on Medicaid more than others. In Ohio's urban centers, 20-30% of the population is covered by Medicaid. Along the Ohio River, there are ten counties where more than 30% of the population is covered by Medicaid -- and 20 counties where Medicaid covers more than 65% of all children under age five. More than half of all Medicaid-eligible Ohioans (57%) are nondisabled children. Children and families make up 78.2% of the Ohio Medicaid population but consume only 30.2% of Medicaid spending.

Each month, Medicaid covers: • 992,000 children (1 out of 3), including 34,000 children with disabilities; • 340,000 parents; • 108,000 seniors; and • 259,000 people with disabilities, including children. Ohio's continuum of health coverage, Medicaid and SCHIP for children and pregnant women is called Healthy Start. Children and pregnant women in families with income at or below 200% of poverty are eligible for Healthy Start (Governor Strickland has proposed increasing eligibility to 300% in his 2010-2011 budget). Pregnant women are eligible for coverage during their pregnancy, including 60 days postpartum, and their newborns are eligible for Medicaid for one year regardless of family income. If a child's parent is also eligible for Medicaid, then the child is enrolled with the parent in Healthy Families. Healthy Families provides health coverage for families with at least one child age 19 or younger and income up to 90% of poverty.

Governor Strickland's goals for health care coverage in Ohio include reducing the number of uninsured Ohioans to 500,000 by 2011 (about half the current number) and increasing the number of small businesses that are able to offer health coverage to their workers. The Governor focused first on seeking to expand Medicaid coverage for children, requested and received federal permission to increase Ohio's Medicaid/SCHIP income test from 200% to 300% of poverty, and included the expansion in his 2010-2011 budget proposal. Ohio recently accepted Secretary Sebelius' challenge to states to enroll all potentially eligible children into the Medicaid program. Ohio recently implemented both presumptive eligibility and continuous eligibility for children, and there are plans to implement express lane eligibility as well.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 22) (Age range to) (Age range to)	2009	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 22) (Age range to) (Age range to)	2009	200

Narrative:
Ohio Medicaid covered 2.2 million Ohioans in 2008 (total annual non-duplicated enrollment). However, because people enter and exit the program throughout the year, Medicaid covered, on average, 1.7 million Ohioans each month. Some low-income areas of the state depend on Medicaid more than others. In Ohio's urban centers, 20-30% of the population is covered by Medicaid. Along the Ohio River, there are ten counties where more than 30% of the population is covered by Medicaid -- and 20 counties where Medicaid covers more than 65% of all children under age five. More than half of all Medicaid-eligible Ohioans (57%) are nondisabled children. Children and families make up 78.2% of the Ohio Medicaid population but consume only 30.2% of Medicaid spending.

Each month, Medicaid covers: • 992,000 children (1 out of 3), including 34,000 children with disabilities; • 340,000 parents; • 108,000 seniors; and • 259,000 people with disabilities, including children. Ohio's continuum of health coverage, Medicaid and SCHIP for children and pregnant women is called Healthy Start. Children and pregnant women in families with income at or below 200% of poverty are eligible for Healthy Start (Governor Strickland has proposed increasing eligibility to 300% in his 2010-2011 budget). Pregnant women are eligible for coverage during their pregnancy, including 60 days postpartum, and their newborns are eligible for Medicaid for one year regardless of family income. If a child's parent is also eligible for Medicaid, then the child is enrolled with the parent in Healthy Families. Healthy Families provides health coverage for families with at least one child age 19 or younger and income up to 90% of poverty.

Governor Strickland's goals for health care coverage in Ohio include reducing the number of uninsured Ohioans to 500,000 by 2011 (about half the current number) and increasing the number of small businesses that are able to offer health coverage to their workers. The Governor focused first on seeking to expand Medicaid coverage for children, requested and received federal permission to increase Ohio's Medicaid/SCHIP income test from 200% to 300% of poverty, and included the expansion in his 2010-2011 budget proposal. Ohio recently accepted Secretary Sebelius' challenge to states to enroll all potentially eligible children into the Medicaid program. Ohio recently implemented both presumptive eligibility and continuous eligibility for children, and there are plans to implement express lane eligibility as well.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's	YEAR	PERCENT OF POVERTY LEVEL

Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		**Medicaid**
Pregnant Women	2009	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	200

Notes - 2011
Data entered for Pregnant Women is the Medicaid % no SCHIP % is applicable.

Narrative:
Ohio Medicaid covered 2.2 million Ohioans in 2008 (total annual non-duplicated enrollment). However, because people enter and exit the program throughout the year, Medicaid covered, on average, 1.7 million Ohioans each month. Some low-income areas of the state depend on Medicaid more than others. In Ohio's urban centers, 20-30% of the population is covered by Medicaid. Along the Ohio River, there are ten counties where more than 30% of the population is covered by Medicaid -- and 20 counties where Medicaid covers more than 65% of all children under age five. More than half of all Medicaid-eligible Ohioans (57%) are nondisabled children. Children and families make up 78.2% of the Ohio Medicaid population but consume only 30.2% of Medicaid spending.

Each month, Medicaid covers: • 992,000 children (1 out of 3), including 34,000 children with disabilities; • 340,000 parents; • 108,000 seniors; and • 259,000 people with disabilities, including children. Ohio's continuum of health coverage, Medicaid and SCHIP for children and pregnant women is called Healthy Start. Children and pregnant women in families with income at or below 200% of poverty are eligible for Healthy Start (Governor Strickland has proposed increasing eligibility to 300% in his 2010-2011 budget). Pregnant women are eligible for coverage during their pregnancy, including 60 days postpartum, and their newborns are eligible for Medicaid for one year regardless of family income. If a child's parent is also eligible for Medicaid, then the child is enrolled with the parent in Healthy Families. Healthy Families provides health coverage for families with at least one child age 19 or younger and income up to 90% of poverty.

Governor Strickland's goals for health care coverage in Ohio include reducing the number of uninsured Ohioans to 500,000 by 2011 (about half the current number) and increasing the number of small businesses that are able to offer health coverage to their workers. The Governor focused first on seeking to expand Medicaid coverage for children, requested and received federal permission to increase Ohio's Medicaid/SCHIP income test from 200% to 300% of poverty, and included the expansion in his 2010-2011 budget proposal. Ohio recently accepted Secretary Sebelius' challenge to states to enroll all potentially eligible children into the Medicaid program. Ohio recently implemented both presumptive eligibility and continuous eligibility for children, and there are plans to implement express lane eligibility as well.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant	2	Yes

birth and infant death certificates		
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	2	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	No
Annual birth defects surveillance system	2	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
Birth and death certificate records are scheduled to be linked annually. However, there is a lag in timeliness of the final analytic file. The most recent linked file is for 2005 births.

The linkage is done at the state Medicaid office in the Ohio Department of Job and Family Services (ODJFS), Ohio Health Plans. The linked files are not always available in a timely manner. Access is achieved through an interagency agreement, however, new projects must now be pre-approved by ODJFS and some have been denied.

WIC and birth certificate records are linked on an ad hoc basis. Linked files include prenatal WIC records with birth certificates for 2005, 2006 and 2007.

Newborn hearing screening results are electronically linked to birth certificates through ODH's Integrated Public Health Information System (IPHIS). ODH does not currently link birth certificates and other newborn screening (blood spot) records. A project is being planned by the ODH laboratory to pilot test the linkage of screening files with birth certificates.
The MCH program has access to subsets of the Ohio Hospital Association (OHA) database per a Memorandum of Understanding between the Ohio Department of Health and the OHA. Requests for up to three projects are considered each year from OHA and resulting reports or presentations are reviewed by OHA.

Ohio's Birth Defects Surveillance System began with pilot data collection in 2005 followed by statewide expansion. The first incidence rates were produced in 2009 for spina bifida. Continued funding to support the system was awarded by CDC NCCDPHP in 2010. With recent increases in information technology support and an increase in epidemiology support from .2 FTE to at least .5 FTE, current focus is on enhancing data quality and system efficiency.

Ohio has participated in PRAMS since April 1999 and has consistently achieved a greater than 65% weighted response rate. However, adequate response rate among African American mothers has been a challenge.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2011

Narrative:
Ohio has been conducting the Youth Risk Behavior Survey (YRBS) since 1993; starting in 2003, the survey has been conducted by ODH, DFCHS. Starting in 2009, CDC has funded ODH to conduct the survey. In 2009, a different sampling frame was attempted that would provide regional statistics. However an adequate response rate was not achieved to meet CDC requirements for weighted statewide results. The altered sampling frame will not be attempted again for the 2011 survey. In addition, the ODH Division of Prevention administers the Youth Tobacco Survey (YTS). The data from these surveys on use of tobacco products by youth is used for needs assessments and to monitor tobacco use among youth.

According to the 2008 Ohio Youth Risk Tobacco Survey, 11.2 percent of Ohio middle school students and 30.1 percent of Ohio high school students were current users of any form of tobacco products. In 2008, among both high school and middle school students, there were no significant differences between males and females regarding current tobacco use. There were also no significant differences between white and black students in middle school or high school with respect to rates of tobacco use. In 2008, eighth-grade students (14.2 percent) were significantly more likely than sixth-grade students (7.2 percent) to be current tobacco users and, 10th-grade students (28.7 percent) were significantly more likely than eighth-grade students (14.2 percent) to be current tobacco users.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Division of Family and Community Health Services (DFCHS) provided stakeholders participating in the Needs Assessment prioritization process with a compilation of quantitative data specific to their population group. The data were primarily organized into topic areas in a fact sheet format. Data sources included state and national Vital Statistics, PRAMS, Youth Risk Behavior Survey (YRBS), www.cdc.gov/nccdphp/dash/yrbs/index.htm, Behavioral Risk Factor Surveillance Survey (BRFSS), www.cdc.gov/brfss/technical_infodata/surveydata.htm, Ohio Family Health Survey (OFHS), http://grc.osu.edu.ofhs, Census, Disease Surveillance and ODH program statistics.

To begin the discussion of health issues, participants reviewed a compiled list of health care issues gathered from a separate stakeholder survey conducted by ODH. This information was sought from practitioners and providers across Ohio and provided a local perspective to the issues for each sub-population. Stakeholders generated a list of recurring themes within these local stakeholder survey results. This list was used as a reference point throughout the needs assessment process. Several of the highest priority health issues cut across more than one sub-population. These cross cutting issues are:

- Access to Care (inclusive of all population groups), including immunizations
- Parent education and support (early childhood, school-age, special needs)
- Birth outcomes/child mortality (women's health, early childhood, special needs)
- Intentional and unintentional injury (inclusive of all population groups)
- Early identification through screening (early childhood, school-age, special needs)
- Disparities in health outcomes (women's health, early childhood, special needs)
- Chronic conditions (school age, special needs), including mental illness, diabetes, substance abuse, asthma, obesity/overweight, sensory deficits and developmental delays

A final prioritization of the identified issues produced the states 9 priorities and subsequent 10 state performance measures.

STATE PERFORMANCE MEASUREs

1. Statewide capacity to reduce unintended pregnancies among populations at risk for poor birth outcomes.
2. Percentage of low birth weight black births among all live black births.
3. Percent of local health departments that provide health education and/or health services in schools.
4. Degree to which DFCHS programs can incorporate and evaluate culturally appropriate activities and interventions
5. Percent of 3rd graders who are overweight.
6. Development and implementation of a core set of preconception health indicators that monitor the health of reproductive age women (18-44) and evaluate preconception health effects.
7. Percent of 3rd graders with untreated caries.
8. Adolescent deaths (age 10-24) due to intentional and unintentional injuries.
9. Maintenance/enhancement of Ohio Connections for Children with Special Needs (OCCSN) BDIS (birth defect registry) to improve utilization of data of surveillance, referrals to services and prevention activities.
10. Percent of children who receive timely, age-appropriate screening and referral.

B. State Priorities

The state has identified the following concerns regarding access to MCH health care and health-related services. The needs assessment process incorporated data required to measure the MCH Block Grant performance and outcome measures and the health status indicators that were being developed by the federal MCH Bureau. The priority areas of greatest concern are organized below by the four levels of the pyramid, and the overall programming strengths and weakness for each population group are outlined at the end of each section.

- Women's Health, Birth Outcomes and Newborn Health

Issues to consider:

- o Health behaviors (nutrition, physical activity, substance use, oral health, breastfeeding)
- o Well woman care (preconception and interconception care)
- o Sexual behaviors and their consequences (unintended pregnancy, STDS, teen pregnancy, family planning/pregnancy prevention)
- o Pre-natal/post-partum care
- o Neonatal care (1st visit, specialist follow up, car seats, back to sleep/safe sleep, shaken baby)
- o Breastfeeding
- o Mental health
- o Safety (safety belts, abuse/violence, living environment)
- o Chronic disease prevention, treatment and management
- o Educational attainment

Strengths and Weaknesses

Currently, Ohio's economy has played a major role in the deficits associated with women and infant health and birth outcomes. The diminishing financial support and revenue sources have helped to erode local program funding or prevented programming from expanding state-wide. Diminished financial support has also contributed to a lack of adequate prenatal care providers. Another weakness has been the lack of available contraceptive services for teens due to the expense of the newer contraceptive methods, and resistance in Ohio for schools to fully address use of contraceptives. In regards to an overall perspective, some of the trends surrounding programming activities have not been fully investigated in order to identify impact, strengthens or weaknesses.

Although, programming weaknesses can be found, Ohio has numerous strengths that have aided MCH programs in weathering the current economic environment. ODH continues to strengthen its collaborative efforts with other state agencies, which promotes the sharing of data, information, and the combining of resources. Additional supplemental funds from Title X have helped to strengthen ODH's capacity to meet MCH needs. In 2009 the charge was given to ODH to create the Ohio Infant Mortality Task Force to address disparities in infant mortality in Ohio's African American community. In 2010, ODH collaborated with Columbus Public Health on the Infant Mortality and Racism Action Learning Collaborative. Additional strengths for women and infant health, is that Ohio has a single breastfeeding coalition and adoption of breastfeeding in the workplace by the Ohio Obesity Plan. In alignment with national performance measure 18, Medicaid has a mandated performance indicator that addresses access to prenatal care for women in their first trimester.

- Early Childhood, School-age, Adolescents and Young Adults

Issues to consider:

- o Risky behaviors including substance use (including tobacco and alcohol), risky sexual behavior, truancy and their consequences
- o Referral to services then diagnosis and treatment (hearing, vision, mental/social-emotional, oral, lead, nutrition, obesity/overweight, early childhood development, asthma, trauma)
- o Inadequate and inappropriate nutrition and physical activity resulting in obesity,

overweight and nutritional deficiencies
- Early care and education (systems approach including all birth to kindergarten services)
- Health, wellness and social development (life skills) are not identified as a part of school achievement
- Safe and supportive environments (schools, neighborhoods) including environmental exposures
- Breastfeeding sustainment

Strengths and Weaknesses
In 2008, 28% of low-income Ohio children aged 2 to 5 years had a BMI at or above the 85th percentile, while 12% were considered to be obese with a BMI at or greater than the 95th percentile. In addition during 2008-2009 18.5% if 3rd graders were obese and 17.4% of third graders were overweight. The data associated with these percentages suggest that low-income Hispanic and Non-Hispanic black 3rd graders were significantly likely to be overweight or obese than non-Hispanic or white children. Although, Ohio is experiencing weaknesses in regards to obesity of its school age children, for its 0 -- 3 age group Ohio's Home Visiting program curricula has had successes with its healthy nutrition programs.

Another area of concern for Ohio is that black and Hispanic children are less likely than white children to have private health insurance. ODH has attempted to convene staff from multiple state agencies to discuss this issue, but was not successful in FFY09. This continues to be an ongoing issue in FFY10, as well as the lack of health insurance coverage for adolescent and young adults transitioning to the adult system for their on-going medical needs.

At the same time, Ohio continues to improve in its capacity to serve the MCH population through efforts like implementing and evaluating programs to determine if they are utilizing evidence-based practices to reduce contributing factors to teen pregnancy. Working with Healthy Child Care Ohio in regards to their efforts to increased child care providers competency to manage children's chronic health care needs. Additional strengths include the increase in social and emotional screenings for children in child care, combined with the fact that the overall death rate for students considering suicide have decreased.

Other infrastructure level strategies that strengthen MCH programs are accomplished by working with AMCHP and collaborating with the Ohio Department of Education in an Action Learning Collaborative on: establishing health education in Ohio public schools; distributing supplemental funds to subgrantees to purchase long-acting reversible contraceptives; monitoring funded subgrantees to assure that they utilize best practices; promoting community outreach activities, and assuring that culturally, age, and education-level appropriate information is available to patients, partners and community members; and collaborating with WIC to use a mobile van to provide pregnancy testing, STI testing, treatment and contraception.

Ohio has demonstrated strength in its capacity to meet the needs of the MCH population through its campaign to increase public and professional awareness of early hearing detection and intervention (EHDI) and distributing educational materials to physicians; preparing and disseminating reports for legislators and others; identifying potential areas for collaboration and working with Au.D. programs and medical schools to incorporate EHDI into curriculums. The Infant Hearing Program and the Genetics Program staff continued to explore ways to collaborate. In the Fall of 2009 the staff began to revise the UNHS Follow-up Hearing Evaluation Reporting form and genetics referral was included. A Genetics Counselor regularly attends Help Me Grow (HMG) training to provide an overview of and literature on genetics.

- Children with Special Health Care Needs

Issues to consider:
- Patient/family centered coordinated care
- Appropriate insurance coverage to provide needed services to CSHCN aged 0-24
- Mental, social, behavioral and developmental health issues

- o Transition to all aspects of adult life including adult care
- o Disintegrated administration of the system of care
- o Newborn screening, genetics services

Strengths and Weaknesses
Ohios capacity, is often challenged when it comes to serving children with special health care needs, due to the complexity and specialized nature of the illness. Providers and parents of this population are often dealing with data systems that are not yet integrated. This is a particular weakness for newborn screening labs and other ODH genetics and sickle cell partners. Children's hospitals do not have access to vital statistics Integrated Public Health Information System (IPHIS) to report screening and paper reports are sent to ODH for data entry.

Timelines for reporting this information is specified in regulations so there is often reliance on goodwill and education to improve the timeliness. However, timeliness of reporting; poor coordination and understanding of IPHIS access at the hospital level; a lack of emphasis on comprehensive accurate reporting and self monitoring create an inability of systems to integrate data.

Ohio currently lacks adequately trained pediatric providers in some geographic areas. Due to reduced funding in recent years it has become increasingly harder to recruit and retain clinicians, especially in specific areas such as Appalachia. The lack of family and provider resources not only in Appalachia but rural and inner city areas lends itself to inadequate or decreased trained pediatric providers or require extensive travel. Adding to this is also the lack of central resources (manpower) to provide more outreach and education to audiologist, primary care providers and for general coordination and troubleshooting.

While these issues exist and can appear to be significant, Ohio has developed numerous strengths in meeting the needs of the CSHCN population. ODH staff monitors the reporting that comes in and can identify specific concerns for outreach and education. In addition, ODH approves hospital protocols to ensure compliance with standards, and uniformity across the state and can offer technical assistance to help generate system integration.

A series of facilitated meetings took place by the DFCHS Leadership to discuss and rank the priorities identified by the stakeholder group's. ODH was able to collectively identify the state's 9 critical MCH priority needs. These 9 critical priorities fall within 3 categories; improve the health of children and adolescents; increase positive pregnancy outcomes and preconception; and system improvement.

The FFY11 Ohio Maternal Child Health Block Grant Priorities are:
1) Increase physical activity and improve nutrition;
2) Increase breastfeeding initiation and duration rates;
3) Improve early childhood development;
4) Decrease rate of smoking for pregnant women, young women and parents;
5) Increase the viability of the health care safety net;
6) Increase the number of women, children and adolescents with a health home;
7) Increase access to evidence based community prevention programs;
8) Increase successful transition of special needs children from pediatric/adolescent to adult health care systems;
9) Improve the availability of useful and accurate health care data and information (this relates to quality and capacity).

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	96.2	25.3	27.3	27.3	3.3
Numerator	179	99	88	88	8
Denominator	186	391	322	322	246
Data Source				ODH Newborn Screening Lab (see notes)	Ohio Newborn Screening Lab (see notes)
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
The ODH Newborn Screening Lab is responsible for calling out abnormal newborn screening results and closing the case with diagnostic information. The Lab has been undergoing a major system upgrade for over a year and during this time they are not recording any treatment information. With improvements to the state's genetics and birth defects data systems, we anticipate collecting more complete treatment information in the coming years.

Notes - 2008
On-going major upgrade at the ODH Newborn Screening Lab: The manufacturer of the MS/MS is the driving force behind the upgrade to the Lab's specimen analysis and associated patient database software systems. This is a comercial product being customized to fit with ODH's system. It has been a multi-year process. In addtion to upgrading the system, the system also has to continue to process blood specimens and keep newborn screening running while the upgrade is going on.

The ODH Genetics Program developed a data system to collect additional newborn screening information to assist with reporting for Form 6. This data system was rolled out in late calendar year 2008. We anticipate improved treatment and longer term follow up information beginning with MCHBG submission in July 2011 (birth data from 2009).

The numerator is currently: # received treatment.
The denominator is: # all confirmed cases.
Together this is not a meaningful measure of accomplishment or progress in newborn screening, as not all confirmed cases require treatment.

Notes - 2007
2007 data are not available; 2006 data are used to estimate 2007 data.

a. Last Year's Accomplishments
Monitor data from regional genetic centers and reconcile with NBS Lab data.
1. Monitor data from genetic centers monthly (completeness, timeliness, accuracy)
2. Compare with NBS Lab data quarterly (# children with abnormal NBS results seen by RCGC

staff)
3. Report data through Annual Data Report (# children identified through NBS seen in RCGC; # children diagnosed with NBS disorders by type of treatment; analysis of timeline from birth, NBS, diagnosis, and treatment).
Data from the new genetic center data system is monitored monthly for newborn screening and other clinical and education event information. A number of issues and errors within the system had to be worked out during FFY 09, which did not enable the genetics data to be used for quarterly reconciliation with the NBS Lab. The NBS Lab is currently undergoing a system upgrade which will allow for access to the NBS Lab system by ODH Genetics staff during FFY10.

Implement consistent hemoglobin trait reporting procedures among Regional Sickle Cell Services Projects.
1. Review current case closing procedures among projects and identify and implement best practice procedures in all centers
2. Implement use of the trait letter in Regional Sickle Cell Services Projects (from sickle cell project to primary care physician)
When the NBS Lab system upgrade is complete, the Regional Sickle Cell Services Projects will have access to, and be able to close hemoglobin trait cases at their locations. This will be implemented in FFY10.

Work with Medicaid, BCMH and WIC to streamline administrative procedures for the provision of metabolic formula to individuals in Ohio. ODH has attempted to convene staff from multiple state agencies to discuss this issue, but was not successful in FFY09. This is an ongoing issue for FFY10.

Participate in Region 4 Genetics Collaborative. ODH is an active participant on the Region 4 Genetics Collaborative, with a number of staff on various work groups. This activity will continue.

Participate with staff at ODH Newborn Screening Lab as they develop a new data system and the impact on case disposition forms, abnormal results letters, and access to the system by staff from Genetics, Sickle Cell and Metabolic Formula Programs. The NBS Lab is upgrading their data system and staff from Genetics, Sickle Cell and Metabolic Formula Programs are kept informed of the activities and provide input on reports that impact these programs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor data from regional genetic centers and reconcile with NBS Lab data.				X
2. Implement consistent hemoglobin trait reporting procedures among Regional Sickle Cell Services Projects.				X
3. Work with Medicaid, BCMH and WIC to streamline administrative procedures for the provision of metabolic formula.				X
4. Participate in Region 4 Genetics Collaborative.				X
5. Participate with staff at ODH Newborn Screening Lab as they develop a new data system.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The percent of screen positive newborns who receive timely follow-up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening program.

1. Monitor data for newborn screening cases between the Genetic Center data system and the ODH Newborn Screening Lab system.

2. Provide access to the ODH Newborn Screening Lab system by Regional Sickle Cell Projects to close hemoglobin trait cases.

3. Participate in the Region 4 Genetics Collaborative.

4. Work with Medicaid, WIC and BCMH to improve provision of special formulas for children who participate in multiple programs.

c. Plan for the Coming Year

1. Monitor and reconcile newborn screening cases between the Genetic Center data system, the Metabolic Formula data system, and the ODH Newborn Screening Lab system.

2. Include newborn bloodspot screening diagnoses and diagnoses related to newborn/infant hearing loss in the state's reportable birth defects panel.

3. Provide access to the ODH Newborn Screening Lab system to Regional Sickle Cell Projects to close hemoglobin trait cases at their locations.

4. Participate in the Region 4 Genetics Collaborative.

5. Work with Medicaid, WIC and BCMH to improve provision of special formulas for children who participate in multiple programs.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**149271**					
Reporting Year:	**2008**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	149271	100.0	117	8	8	100.0
Congenital Hypothyroidism	149271	100.0	1004	60	0	0.0

(Classical)						
Galactosemia (Classical)	149271	100.0	80	27	0	0.0
Sickle Cell Disease	149271	100.0	90	77	0	0.0
Biotinidase Deficiency	149271	100.0	4	4	0	0.0
Congenital Adrenal Hypoplasia	149271	100.0	541	9	0	0.0
Cystic Fibrosis	149271	100.0	513	45	0	0.0
Homocystinuria	149271	100.0	247	0	0	
Maple Syrup Urine Disease	149271	100.0	38	0	0	
Sickle Cell Trait	149271	100.0	4109	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	149271	100.0	10	2	0	0.0
Argininemia	149271	100.0	67	0	0	
Argininosuccinic Acidemia	149271	100.0	2	1	0	0.0
Isovaleric Acidemia	149271	100.0	14	0	0	
Carnitine Uptake Defect	149271	100.0	1	1	0	0.0
Methylmalonic acidemia (Cbl A,B)	149271	100.0	91	5	0	0.0
Glutaric Acidemia Type I	149271	100.0	5	0	0	
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	149271	100.0	20	7	0	0.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	149271	100.0	7	0	0	
Isobutyryl-AoA Dehydrogenase Deficiency(SCADD)	149271	100.0	1	1	0	0.0
Carnitine Acylcarnitine Translocase Deficiency	149271	100.0	0	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	75	75	75	75
Annual Indicator	59.3	59.3	65.4	65.4	65.4
Numerator					
Denominator					

Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	75	75	75	75	75

Notes - 2009
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2008
Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
Empower families to work in partnership with providers for decision making.

1. Create a "regional page" on BCMH web site and link to regional resource and referral web sites. Placed the Parent Handbook on BCMH website and have links to the Cincinnati Resource Center. Continuing to link with 211 and Benefit Bank.

2. Partner with Family VOICES of Ohio to strengthen regional family activities.
Received a Family to Family grant and established four (4) regional referral centers to work with families.

3. Implement activities related to core component #1 of the Integrated Systems Grant. Core Component #1 is Family/professional partnership at all levels of decision making. BCMH has an active Parent Advisory Committee and Youth Advisory Councils throughout the state. BCMH encourages parental leadership in the medical homes throughout the state.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Create a regional page on BCMH web page and link to resources.		X		
2. Partner with Family VOICES to strengthen regional family activities.		X		

3. Implement activities related to Integrated Systems Grant core component #1 regarding family/professional partnerships.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Empower families to work in partnership with providers in decision making.

1. Place Family Manual on BCMH website. DONE/in maintenance mode

2. Partner with Family VOICES of Ohio to strengthen regional family activities. ONGOING

3. Link families to 211 and benefit bank. ONGOING

c. Plan for the Coming Year
Empower families to work in partnership with providers in decision making.

1. Continue to develop BCMH web site and link to regional resources as they become available.

2. Continue to partner w/Family VOICES of Ohio, Family to Family Centers to strengthen regional family activities.

3. Link families to 211 and the benefit bank.

4. Provide information/training to local health departments in use of benefit bank.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	60	60	60	60
Annual Indicator	55.9	55.9	55.6	55.6	55.6
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore					

a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	60	60	60	60	60

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
Strengthen Medical Home, particularly in the area of coordination of services for families and providers.

1. Continue to support Cincinnati Children's Hospital Resource Directory (web-based)
BCMH continues to support Cincinnati Children's Hospital Resource Directory and is on its advisory committee.

2. Develop and implement a pilot program for medical home office-based service coordination.
This is on hold.

3. Work with BEIS and ODJFS foster care system to improve the medical home for children in foster care. BCMH is working with Ohio Chapter AAP, BEIS and ODJFS to strengthen medical homes for children in foster care.

4. Coordinate with BEIS and Ohio Chapter of AAP on implementation of the ODH Autism grant to connect medical home to autism services. BCMH continues to work closely on implementation of the ODH Autism grant. It has incorporated it into all BCMH activities.

Implement activities related to core component #2 of the Integrated Systems Grant - This is on hold.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support Cincinnati Children's Hospital web-based resource directory.				X
2. Develop and implement pilot program for office-based service coordination.				X

3. Work with BEIS and ODJFS foster care system to improve medical homes.				X
4. Coordinate with BEIS and Ohio Chapter of AAP on implementation of ODH Autism grant.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Strengthen medical home, particularly in the area of coordination of services for families and providers.

1. Continue to support Cincinnati Children's Hospital Resource Directory (web-based). ONGOING

2. Evaluate pilot program for Medical home office based service coordination. Dept. of Insurance taking lead of analysis.

3. Link to AAP care notebook for foster parents on BCMH website. AAP did not put notebook on their website. Unable to complete. Looking into posting notebook directly on our website.

4. Coordinate with BEIS and Ohio Chapter of AAP on statewide expansion of the ODH Autism grant to connect medical hone to autism services. Coordination is being headed by the state Interagencey Work Group on Autism. ONGOING

5. Collaborate with Medicaid Children's Bureau on State Interagency Group on Service Coordination. ONGOING

c. Plan for the Coming Year
Strengthen medical home, particularly in the area of coordination of services for families and providers.

1. Continue to support Cincinnati Children's Hospital Resource Directory (web-based).

2. Work with Ohio Chapter of AAP to link to foster care notebook

3. Finalize connection to ODH BEIS medical home autism services

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	75	75	75	75
Annual Indicator	60.8	60.8	64.6	64.6	64.6
Numerator					

Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	75	75	75	75	75

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
Strengthen Medical Home, particularly in the area of coordination of services for families and providers.

1. Continue to support Cincinnati Children's Hospital Resource Directory (web-based)
BCMH continues to support Cincinnati Children's Hospital Resource Directory and is on its advisory committee.

2. Develop and implement a pilot program for medical home office-based service coordination.
This is on hold.

3. Work with BEIS and ODJFS foster care system to improve the medical home for children in foster care. BCMH is working with Ohio Chapter AAP, BEIS and ODJFS to strengthen medical homes for children in foster care.

4. Coordinate with BEIS and Ohio Chapter of AAP on implementation of the ODH Autism grant to connect medical home to autism services. BCMH continues to work closely on implementation of the ODH Autism grant. It has incorporated it into all BCMH activities.

Implement activities related to core component #2 of the Integrated Systems Grant. This is on hold.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with key stakeholders in expansion of Medicaid for Children and Children's Buy In.				X
2. Continue work with consumers and providers on implementation of new therapy rules.				X
3. Survey consumers who have opted out of Medicaid Managed Care and provide results.				X
4. Add questions on data capacity relative to CSHCN on Ohio Family Health Survey.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Promote awareness of public and private sources of financing of needed health care services to providers, stakeholders and families of CSHCN.

1. Work with key stakeholders in expansion of Medicaid for Children/SCHIP information has been presented to BCMH stakeholders

2. Conduct analysis on Ohio Family Health Survey question on data capacity relative to CSHCN report completed

c. Plan for the Coming Year
Promote awareness of public and private sources of financing of needed health care services to providers, stakeholders and families of CSHCN.

1. Work with key stakeholders in expansion of Medicaid for Children/SCHIP and Children's Buy-In Program

2. Train local health departments, hospital based services coordinators on state and federal changes.

3. Continue to maintain CSHCN data capacity by including questions in the Ohio Family Health Survey relative to CSHCN.

4. Provide educational material regarding impact of federal health care reform for CSHCN on web-site.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009

Annual Performance Objective	90	90	90	95	95
Annual Indicator	80.2	80.2	92.2	92.2	92.2
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	95	95	95	95	95

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
Strengthen Medical Home, particularly in the area of coordination of services for families and providers.

1. Continue to support Cincinnati Children's Hospital Resource Directory (web-based)
BCMH continues to support Cincinnati Children's Hospital Resource Directory and is on its advisory committee.

2. Develop and implement a pilot program for medical home office-based service coordination.
This is on hold

3. Work with BEIS and ODJFS foster care system to improve the medical home for children in foster care. BCMH is working with Ohio Chapter AAP, BEIS and ODJFS to strengthen medical homes for children in foster care.

4. Coordinate with BEIS and Ohio Chapter of AAP on implementation of the ODH Autism grant to connect medical home to autism services. BCMH continues to work closely on implementation of the ODH Autism grant. It has incorporated it into all BCMH activities.

Implement activities related to core component #2 of the Integrated Systems Grant. This is on hold.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work to develop a system of care for CSHCN in the Youngstown area by partnering with Akron Children's Hospital and other children's hospitals.				X
2. Work with Ohio Family VOICES and other parent groups to address needs.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Promote organization of community-based services so that CSHCN families report they can use them easily.

1. Reintegrate hospital-based service coordination teams in the Youngstown area. ONGOING RECRUITMENT

2. Work with Ohio Family VOICES and other parent groups to assess needs of families including cultural needs through culturally competent care. ONGOING

3. Promote usage of Benefit Banks to assist families fill out CPA. ONGOING

4. Work with Help Me Grow (HMG) in awareness and use as a system of payment to streamline for families. ONGOING (SYSTEM HAS BEEN DESIGNED AND IN USE)

c. Plan for the Coming Year
Promote organization of community-based services so that CSHCN families report they can use them easily.

1. Strength system of care in Youngstown area relative to CSHCN as new hospital systems are completed

2. Work with Ohio Family VOICES and other parent groups to address community-based weaknesses.

3. Promote usage of Benefit Banks to assist families in filling out CPA and other assistance materials.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	25	25	25	50	50
Annual Indicator	5.8	5.8	48.5	48.5	48.5
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	50	50	50	50

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
Maintain a forum for youth with special health care needs to discuss needs and receive information on services and supports

1. Conduct quarterly, regional meetings with the Young Adult Advisory Council (YAAC) (add NW

region). BCMH conducts quarterly regional meetings with the YAACs and worked on adding a NW region YAAC.
2. Invite pertinent agencies/staff to present at YAAC meetings, i.e., Rehab Services Commission, SSI, genetic counselors. At the quarterly meetings, appropriate agencies and staff presented and engaged the councils in dialogue.
3. Recruit and educate physician providers for youth. BCMH continues to recruit physician providers for youth in transition. This is an ongoing activity.

Educate Policy Makers as to needs for Insurance Coverage for Young Adults with Medical Needs

1. Continue to develop regional transition teams to ensure medical care
Transition work continues regionally in coordination with children's hospitals and other regional providers.
2. Educate policy makers as to insurance coverage for young adults with medical needs
BCMH continues to educate legislators and others in medical and insurance needs of young adults with special needs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conduct quarterly regional meetings with Young Adult Advisory Council.				X
2. Invite pertinent agencies to present at YAAC meetings.				X
3. Recruit and educate physician providers for youth.				X
4. Develop regional transition teams.				X
5. Educate policy makers about insurance coverage for young adults with medical needs.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Maintain a forum for youth with special health care needs and receive information on services and supports.

1. Conduct quarterly regional meetings with Young Adult Advisory Council. ONGOING
2. Invite pertinent agencies/staff to present at YAAC meetings, i.e. Rehab Services Commission, SSI, Genetic Counselors. ONGOING
3. Recruit and educate physician providers for youth. ONGOING
4. Develop Webinar on transition. NOT COMPLETED

Educate policy makers as to needs for insurance coverage for young adults with medical needs.

1. Educate policy makers as to needs for insurance coverage for young adults with medical needs. ONGOING through PAC
2. Continue to work with OCALI and BVR to develop regional transition teams to ensure medical care. ONGOING

c. Plan for the Coming Year

Maintain a forum for youth with special health care needs and receive information on services and supports

1. Conduct quarterly regional meetings with Young Adult Advisory Council YAAC)
2. Expand regions of the YAAC
3. Recruit physician providers for youth transitioning to adult care.
4. Provide trainings to youth regarding impact of federal health care reform

Educate policy makers as to needs for insurance coverage for young adults with medical needs.

1. Work with Ohio Chapter of AAP on developing regional transition teams for youth
2. Work with Ohio Chapter of AAP to educate policy makers to insurance needs for youth transitioning to adult care

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	84	84.5	85	85.5	86
Annual Indicator	84.1	81.3	80.4	80.4	80.4
Numerator	187429	180619	172568	172568	172568
Denominator	222864	222163	214637	214637	214637
Data Source				National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	86	86	86	86	86

Notes - 2009
The 2009 data is currently not available we have used the 2008 data as an estimate for 2009.

Notes - 2008
2008 data are not available. 2007 data were used to estimate 2008.

Notes - 2007
2007 data are not available. 2006 data were used to estimate 2007.

a. Last Year's Accomplishments

Monitor immunization data from DCFHS funded programs.
This infrastructure-level strategy was accomplished by analyzing WIC data (80 percent of the children in the 19-35 month age range were up to date on their immunizations) and CFHS data (83 percent of children were fully immunized). The percent of 19-35 mo olds who received a full schedule of age appropriate immunizations (4.3.1.3.3) -in Ohio was 80.4 (±5.5) for 2007 per CDC's National Immunizations Survey.

Promote the use of the statewide immunization registry by DFCHS funded programs.
This infrastructure-level strategy was accomplished by monitoring 24 CFHS subgrantees providing child health services; working with BCHS to promote an awareness campaign within schools that have school-based clinics; and working with the Rural Health program to promote provider awareness at the annual Rural Health Conference.

Collaborate and coordinate immunization planning and programming efforts with national, state and local health programs.
This infrastructure-level strategy was accomplished by collaborating with the ODJFS Immunization Advisory group and other stakeholder groups; and by working with local WIC projects to ensure that children are referred for immunization services. Of the 71 subgrantees funded by the CFHS Grant, 47 percent have included immunization strategies in their program plan.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor immunization data from DCFHS funded programs.				X
2. Promote the use of the statewide immunization registry by DFCHS funded programs.				X
3. Collaborate and coordinate immunization planning and programming efforts with national, state and local health programs.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Monitor immunization data from DCFHS funded programs. This infrastructure-level strategy is being accomplished by analyzing data, including trends, from the CFHS program utilizing the MATCH data collection system.

Promote the use of the statewide immunization registry by DFCHS funded programs
1. Monitor those CFHS subgrantees providing child health services.
2. Work with the Rural Health program to promote provider awareness at the annual Rural Health Conference.
3. Monitor immunization status by HMG service providers upon program entry and exit.

Collaborate and coordinate immunization planning and programming efforts with national, state and local health programs. Collaborate with the ODJFS Immunization Advisory group and other stakeholder groups.

c. Plan for the Coming Year
Monitor immunization data from DCFHS funded programs. This infrastructure-level strategy will be accomplished by analyzing data from the following sources: CFHS program (MATCH) and WIC program.

Promote the use of the statewide immunization registry by DFCHS funded programs. This infrastructure-level strategy will be accomplished by 1) monitoring those CFHS subgrantees providing child health services; 2) working with BCHS to promote an awareness campaign within schools that have school-based clinics; and 3) working with the Rural Health program to promote provider awareness at the annual Rural Health Conference.

Collaborate and coordinate immunization planning and programming efforts with national, state and local health programs. This infrastructure-level strategy will be accomplished by collaborating with Ohio Health Plans (Medicaid) and other stakeholder groups; and by working with local WIC projects to ensure that children are referred for immunization services.

Incorporate culturally appropriate activities and interventions-refer to activities in State Performance Measure 04.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	18	18	18	18	18
Annual Indicator	19.6	19.8	19.7	19.7	19.7
Numerator	4710	4836	4798	4717	4717
Denominator	240837	244467	243435	239491	239491
Data Source				Ohio Vital Statistics and US Census	Ohio Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	18	18	18	18	18

Notes - 2009
The 2009 data is currently not available. 2008 data has been used as an estimate for 2009.

Notes - 2008
2008 data are not available; 2007 data were used as estimates

Notes - 2007

Data for denominator from US Census Bureau, 2007 population estimates. Numerator from OH resident births, final 2007 Vital Statistics birth file.

a. Last Year's Accomplishments
Analyze PRAMS data reported by teen mothers to identify issues specific to this population to determine next steps and recommendations for further research.

PRAMS data was analyzed and reported for the following topics: teen births, intimate partner violence, and unintended pregnancy. The Family Planning program developed a state-wide family planning needs assessment to examine the broader reproductive and community health issues affecting reproductive age women in Ohio. The program used a community health assessment and program planning model to identify and analyze problems, needs, assets and capacity as well as resources and capacity to address priority needs. Key issues identified included health status, education and outreach, improving cultural competence, capacity, evaluation and community measures. Health indicators/priorities were finalized to the following: access to family planning services, unintended pregnancy, contraception, prenatal care, pap smears/cervical cancer, infant mortality rates, nutrition/obesity and birth spacing/inter-pregnancy intervals. Data sheets resulting from the needs assessment have been posted on the ODH website: http://www.odh.ohio.gov/healthStats/data/mchfact/factsheets.aspx.

Evaluate BCFHS programs to determine if they are utilizing evidence-based practices to reduce contributing factors to teen pregnancy.
The pregnancy rate for teenagers aged 15 through 17 years while decreasing for years has remained static from 2002-2006. The pregnancy rate for teenagers aged 18-19 decreased from 1997-2004 and has increased slightly from 2004-2006. Program is collaborating with Ohio Department of Education in an Action Learning Collaborative (sponsored by AMCHP) to establish health education in the Ohio public schools. The Family Planning Program was awarded supplemental funds for subgrantees to purchase long-acting reversible contraceptives to provide patients with more effective contraceptive methods. Program monitors every funded entity to assure that they utilize best practices; employ community outreach activities; apply evaluation methodology to all activities; and assures that culturally, age, and education-level appropriate information is available to patients, partners and community members.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Analyze and report PRAMS data on the following topics: teen births, intimate partner violence, and unintended pregnancy.				X
2. Conduct and report (via ODH website) on a state-wide family planning needs assessment to examine the broader reproductive and community health issues affecting reproductive age women in Ohio.				X
3. Actively engage in a collaboration between FP and ODE in the Action Learning Collaborative (sponsored by AMCHP) to establish teen health education in the Ohio public schools.				X
4. Assure via site visits FP subgrantees are utilizing best practices employ community outreach; apply evaluation methodology to all activities; & assure culturally, age, and education-level appropriate info is available.				X
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
Compare PRAMS data, county data and program data to identify issues specific to this population to determine service needs and funding levels to serve this target audience. Infrastructure level strategy is accomplished by combining three family planning (FP) programs into one program with common indicators, goals, objectives and evaluations; identifying regional pools of counties to provide FP services to affect fiscal efficiencies and to increase the assets and capacity as well as resources to address priority needs; and changing health indicators/priorities to include: access to care, risk behavior, preconception health, and medical care.

Evaluate BCFHS programs to determine if they are utilizing evidence-based practices to reduce contributing factors to teen pregnancy. Infrastructure level strategy is accomplished by working with AMCHP to collaborate with Ohio Department of Education in an Action Learning Collaborative to establish health education in Ohio public schools; distributing supplemental funds to subgrantees to purchase long-acting reversible contraceptives; monitoring funded subgrantees to assure that they utilize best practices, community outreach activities and apply evaluation methodology to all activities and assure that culturally, age, and education-level appropriate information is available to patients, partners and community members; and collaborating with WIC to use a mobile van to provide pregnancy testing, STI testing/treatment and contraception.

c. Plan for the Coming Year
Analyze PRAMS data reported by teen mothers to identify issues specific to this population to determine next steps and recommendations. This infrastructure level strategy will be accomplished by evaluation FP to determine if they are utilizing evidence-based practices to reduce contributing factors to teen pregnancy.

Evaluate FP programs to determine if utilizing evidence-based practices reduce teen pregnancy. This infrastructure level strategy will be accomplished by establishing a requirement in the FP RFP that applicants document use of at least one evidence based teen pregnancy prevention strategy; and train all FP nurses to provide intervention to teens reporting sexual coercion.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	44	45	47	48	51
Annual Indicator	42.7	43.6	42.2	50.9	50.9
Numerator	5992	410	53703	64341	64341
Denominator	14029	941	127146	126407	126407
Data Source				Annual School Survey	Annual School Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	51	51	52	52	52

Notes - 2007
Data Source: From the 2006/2007 Annual Sentinel School Survey of 25 schools which provided a population-based estimate for the state. Numerator: Actual number of children in the sample who received protective sealants = 473 (population estimate = 53703). Denominator: Actual number of children in the sample who were screened = 1147 (population estimate = 127146).

a. Last Year's Accomplishments
In FFY2009, 43.5 percent of third graders in Ohio had protective dental sealants on at least one permanent molar tooth (55,299/127,099).

Fund (through subgrants) local agencies to operate efficient, high quality school-based dental sealant programs.
Data for the Free and Reduced Price Meal Program (FRPMP) was reviewed for school eligibility for the program. Sealant programs added schools, generally one or two, as capacity permitted. Analysis of program data resulted in a change in the criterion for a school's eligibility for participation in the sealant program. FRPMP eligibility at a school must be 40% (previously 50%) or more of the children enrolled, with priority given to schools at 50% or more of the children enrolled. Sixteen dental sealant programs were funded to provide dental sealants to high risk students in 40 Ohio counties; these programs reported providing dental sealants to 19,290 students.
The Ohio School-based Dental Sealant Program At-A-Glance map, summary data, including the number of students served in 2008-09, has been updated.

Improve quality in sealant subgrant programs.
A School-based Dental Sealant Program Manual and Program Improvement Plan were developed for program quality assurance. The manual, posted on the ODH Web site, was updated in September 2009. Information about both documents and program expectations was shared with Ohio sealant programs at a meeting in August 2009. Quarterly program reports were reviewed and technical assistance provided to programs where concerns were identified. A program identified with a poor long-term retention of sealants received technical assistance, resulting in improved retention of sealants. Site visits were conducted with two programs. Training and technical assistance was provided for all programs as ODH's required electronic reporting system, the Subgrantee Performance Evaluation System, (SPES) was implemented.

It was determined that the SEALS program did not currently meet BCHS' needs (e.g., no Medicaid billing component) and was not implemented. ODH subgrantees began reporting via SPES, the required electronic subgrantee reporting system, in 2009.

Evaluate effectiveness of the BCHS approach to funding school-based sealant programs.
Following a review of other states funding systems and an analysis of BCHS program trend data, BCHS elected to continue its current system of funding sealant subgrants (based on cost per child) to local agencies. These agencies provide cost-effective dental sealant programs at schools targeted on the basis of student enrollment for the FRPMP. BCHS programs are required to bill and collect Medicaid reimbursement for dental sealants. The anticipated amount of Medicaid to be collected increased, based on an analysis of programs' recent reporting of billing and collections.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Fund 16 local agencies to operate efficient, high quality school-based dental sealant programs in 40 counties serving almost 20,000 students.				X
2. Update The Ohio School-based Dental Sealant Program At-A-Glance map, summary data, including the number of students served in 2008-09.				X
3. Improve quality in sealant subgrant programs by updating a school based dental sealant manual and Program Improvement Plan were developed for program quality assurance.				X
4. Evaluate effectiveness of the BOHS approach to funding school-based sealant programs.				X
5. Implement training and technical assistance for all programs as ODH's required electronic reporting system, the Subgrantee Performance Evaluation System, (SPES).				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Fund (through subgrants) local agencies to operate efficient, high quality school-based dental sealant programs.
This infrastructure-level strategy will be accomplished through the following activities:

1) implement the plan for expanding the number of schools and children served by ODH-funded sealant programs;

2) evaluate and update the Ohio School-based Dental Sealant Manual and Performance Improvement Plan based on implementation in 2010. The evaluation will be based on an analysis of quarterly report data, site visits and other documentation, and site visits.

3) update, as appropriate, the on-line distance learning curriculum for school-based sealant program staff.

c. Plan for the Coming Year

Fund (through subgrants) local agencies to operate efficient, high quality school-based dental sealant programs.
This infrastructure-level strategy will be accomplished through the following activities:

1) implement the plan for expanding the number of schools and children served by ODH-funded sealant programs;

2) evaluate and update the Ohio School-based Dental Sealant Manual and Performance Improvement Plan based on implementation in 2010. The evaluation will be based on an analysis of quarterly report data, site visits and other documentation, and site visits.

3) update, as appropriate, the on-line distance learning curriculum for school-based sealant

program staff.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.4	2.4	2.4	2.5	1.5
Annual Indicator	2.6	2.7	1.6	1.9	1.9
Numerator	59	58	33	40	40
Denominator	2264102	2122965	2104949	2087807	2087807
Data Source				Ohio Vital Statistics and US Census	Ohio Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	1.5	1.5	1.5	1.5	1.5

Notes - 2009
The 2009 data is currently not available. 2008 data has been used as an estimate for 2009.

Notes - 2008
2008 data are not available. 2007 data are used to estimate 2008 data.

Notes - 2007
Numerator: Ohio Vital Statistics 2007 final death file
Denominator: U.S. Census/NCHS Bridged Race, Vintage 2007 Ohio population estimates for 2007

a. Last Year's Accomplishments
Rate of deaths was analyzed using Vital Statistics data. Contributing factors of motor vehicle crash fatalities for children under 18 years have been monitored and analyzed via child fatality review (CFR) data. CFR data for children 1-14 years old was further analyzed. 353 deaths in 2007 to 1-14 year olds were reviewed; 37 were vehicular deaths. This is 33% of all vehicular deaths reviewed; 10% of all 1-14-year-old deaths; and 26% of all non-natural deaths (142) to 1-14 year olds. These percentages are slightly lower than in past years.

Analysis of the 37 vehicular deaths found that 18 involved death of child passengers, 2 involved death of child drivers, and 15 were cyclists or pedestrians. Both child drivers killed were on ATVs. Of the 16 vehicular deaths to black children, 7 (44%) were 1-14 year olds. Of the 13 deaths to 1-14 year olds in vehicles where restraint use is required by law, 7 (54%) were not properly restrained. ODPS data confirm observed restraint use is highest in SW region and lowest in SE region of state. CFR Annual Report and data were shared at many division meetings and overlapping work groups; CFR trainings; Combined Public Health Conference;

Ohio Public Health Epidemiology Conference; Ohio Injury Prevention Partnership and CFR Advisory Committee and subgroup meetings. Report was announced through media releases to newspapers, television and radio stations; and posted on ODH Website. Copies were distributed throughout ODH and to elected officials, local CFR boards, Family and Children First Councils, and State Library system.

CFR boards are encouraged to seek collaboration from community agencies to develop activities and initiatives in response to CFR findings. Technical assistance was provided to CFR boards regarding effective ways to solicit and communicate with partners. Local boards partnered with schools and service organizations to provide bike and pedestrian safety events, free bike helmets and seat belt use incentives. Cooperation with law enforcement and traffic engineers resulted in roadway improvements, media messages re: driveway safety and targeted passenger restraint education. Many CFR boards are active in broadcasting changes in Ohio's Graduated Driver License law and advocating for strict enforcement by parents and law enforcement. CFHS projects were encouraged to include local CFR findings in community assessments and program planning.

The ODH Injury Prevention (IP) program works closely with the Ohio Department of Public Safety/Ohio Traffic Safety Office (ODPS/OTSO) to address child passenger safety (CPS) issues. With car seat fine dollars, ODH purchases safety seats that are distributed through a network (Ohio Buckles Buckeyes) of CPS programs. Each county has an agency designated to provide education and distribute CPS seats at no cost to families who meet financial eligibility criteria. Grant from ODPS/OTSO supports these activities. Through grant, ODH has assumed responsibility for Occupant Protection Regional Coordinator (OPRC) Program, a network of nine regional CPS instructors and coordinators who provide training and technical assistance to local Ohio Buckles Buckeyes sites. OPRCs also plan and coordinate other occupant protection activities in their regions including CPS check-up events and fitting stations. Grant funds are also used to purchase and print CPS educational materials, including materials to promote Ohio's new booster seat law, effective 10/7/2009. New website was created with booster seat-related information and resources. Memorandum of Understanding was signed by Director of Health and Director of ODPS for sharing of data from Trauma and EMS Registries. IP staff member is a member of Ohio CFR Advisory Committee where death to children resulting from motor vehicle crashes has been priority. IP coordinates multi-disciplinary, statewide injury prevention coalition in which CFR coordinator and members of OTSO are participating in efforts to improve injury prevention collaboration. Child Injury Action Group was created and will develop specific action plans to address priority child injury areas over next year.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Analyze and report rate of deaths and contributing factors of motor vehicle crash fatalities for children under 18 years using VS and CFR data.				X
2. Disseminate CFR Annual Report via multiple channels, including division meetings; CFR trainings; conferences; media releases to newspapers, TV & radio; and posted on ODH Website; sent to elected officials, local CFRBs, FCFCs, and State Libraries.				X
3. Provide technical assistance to CFR boards regarding effective ways to solicit and communicate with partners.				X
4. Work closely with ODH Injury Prevention (IP) program and the Ohio Department of Public Safety/Ohio Traffic Safety Office (ODPS/OTSO) to address child passenger safety (CPS) issues.				X
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

Use data to monitor rate of MV deaths to children 1-14 yrs old; percentage of MV deaths among all deaths reviewed; and county of MV deaths. Infrastructure-level strategy accomplished by identifying data quality issues; accessing injury data sources for impact of MV crashes for 1-14 yr olds.

Analyze factors that contribute to MV deaths of children 1-14 yrs old using CFR data, crash report data from ODPS and share information with stakeholders. Infrastructure-level strategy accomplished by analyzing groups w/increased risks; continuing MV focus section in CFR annual report; using multiple venues to disperse findings.

Encourage CFR Boards to share information/recommendations about prevention of MV deaths of children 1-14 yrs old with local partners who can reach families and children. Infrastructure-level strategy accomplished by providing TA, training to CFR boards re: presentation to audiences; encouraging cultural and linguistic competency in activities; working to strengthen collaborations between CFR and CFHS; preparing fact sheets of death data and risk factors unique to age group.

Collaborate w/ ODH injury programs and state agencies to develop strategies to decrease MV injuries and deaths among children. Infrastructure-level strategy accomplished by educating partners re: issues, priorities, need to collaborate for solutions; using recommendations to engage partners, leverage influence/coordinate efforts to identify/ implement changes to policy, practice or legislation.

c. Plan for the Coming Year

Use Vital Statistics data to monitor rate of MV deaths to children 1-14 yrs old. Use Child Fatality Review (CFR) data to monitor percentage of MV deaths among deaths reviewed. Use Ohio Department of Public Safety (ODPS) crash report data to monitor county of MV deaths. This infrastructure-level strategy will be accomplished through the following activities: Be alert to possible data quality issues; Access additional data sources that include injury data to provide a more comprehensive look at the impact of MV crashes for 1-14 yr olds.

Analyze factors that contribute to MV deaths of children 1-14 yrs old using CFR data and crash report data from ODPS. Share information with ODH programs, state agencies, local health departments, child health partners and policymakers/legislators. This infrastructure-level strategy will be accomplished through the following activities: Use analysis to identify groups with increased risks across the age group; Include injury data for more comprehensive perspective; Continue MV focus section in CFR annual report; Use strategy workgroup plus other external partners to review data and give input; Use multiple venues to disperse findings, e.g., ODH Website, e-mails, conference exhibits and presentations.

Encourage local CFR Boards to share information and recommendations about prevention of MV deaths of children 1-14 yrs old with local partners who can reach families and children, e.g., local media, Help Me Grow, county Family and Children First, Ohio Buckles Buckeyes, service agencies such as Kiwanis Clubs, child care providers and legislators. This infrastructure-level strategy will be accomplished through the following activities: Provide TA, training and tools to local CFR boards re: ways to present and share information to audiences, including use of CFR data for funding applications; Encourage cultural and linguistic competency in development of

activities to prevent deaths and injuries from MV crashes, especially for pedestrian safety in urban areas and for educating public about new child booster seat law; Work with CFHS Program Consultants to strengthen collaborations between local CFR boards/CFHS projects; Review CFHS work plans and activities related to required strategy for CFR; Prepare fact sheets from data for MV deaths to 1-14 yr olds and risk factors unique to age group.

Collaborate with injury programs at ODH and other state agencies, to develop strategies to decrease MV injuries and deaths among children, including proper use of safety devices and increasing pedestrian safety. This infrastructure-level strategy will be accomplished through the following activities: Educate partners regarding issues, priorities and need to collaborate for solutions; Use CFR Advisory Committee, strategy workgroup and Ohio Injury Prevention Partnership recommendations to engage partners, leverage influence and coordinate efforts to identify and implement changes to policy, practice or legislation to reduce child MV deaths

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		28	34	34.5	35
Annual Indicator	33.3	31.5	31.5	31.4	31.4
Numerator	49469	46700	46700	46700	46700
Denominator	148555	148255	148255	148592	148592
Data Source				CDC National Immunization Survey	CDC National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	35.5	36	36	36	36

Notes - 2009
The 2009 data is currently not available. 2008 data has been used as an estimate for 2009.

Notes - 2008
Data for the most recent year are not yet available from the CDC National Immunization Survey - Breastfeeding Module. It is expected that these data will be available in August 2009. Data from the previous year are used as an estimate.

Notes - 2007

Breastfeeding data from the CDC National Immunization survey are two years behind the MCH BG reporting year. so data from the 2005 reporting year are used to estimate 2007 data.

a. Last Year's Accomplishments

Participate in state breastfeeding (BF) coalition.
1. Bi monthly teleconferences were hosted. ODH provided conference line and was promoted to stakeholders across Ohio.
2. Ohio Department of Health (ODH) chose not to join either of the competing statewide coalitions this year.

Strengthen BF in Ohio Infant Mortality Reduction Initiative (OIMRI) program.
1. We developed a baseline Community Health Worker (CHW) Survey for the OIMRI program.
2. The breastfeeding training was provided to several Community Health Workers (CHW) through WIC.
3. The activity to explore cross-program coordination in one county was not accomplished.
4. The activity to review of BF elements of proposed OIMRI data system was not accomplished.
5. Interviewed several potential CDC fellows; none chose Ohio.

Support BF components of ODH child obesity plan that is under development.
1. Ensured inclusion of breastfeeding objectives and activities in the Ohio Obesity Prevention Plan. Finalized March 2009.
2. No fellow was secured.

Review 2007 birth certificate BF data.
1. None done. However, evaluation of BF Peer Helper Program in WIC was completed. Discovered Peer Helper Program improved BF rates among White mothers but not in African American mothers.
2. The activity to review rates in African American (AA) mothers and in women in Appalachian counties was not accomplished.

Learn about BF in the Appalachian culture to assist in planning strategies/activities.
1. The activity to review literature re: BF and Appalachia was not accomplished.
2. The activity to communicate with BF/other coalitions in Appalachian counties was not accomplished.
3. The activity to explore primary data collection for new information was not accomplished.

A. Increase BF among Ohio AAs.
1. The activity to work with: OIMRI; AA health professional/advocacy organizations and ODH's Health Equity Coordinator to improve AA BF rates. Invite reps. to be members of BF workgroup was not accomplished. OIMRI Child and Family Health Services (CFHS) program consultant was invited to the workgroup.
2. The activity to assess if ODH program BF messages are culturally appropriate for AA audiences was not accomplished.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in state breastfeeding (BF) coalition.				X
2. Strengthen BF in Ohio Infant Mortality Reduction Initiative (OIMRI) program by developing an implementing a training on BF provided by WIC staff.				X
3. Evaluate the BF Peer Helper Program in WIC to determine if BF rates are improved among clients.				X
4. Ensure that BF objectives and activities are incorporated into				X

the Ohio Obesity Prevention Plan.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Support BF components among ODH child obesity plan.
BF objectives were included in the Preventing Infant Mortality in Ohio: Task Force Report.
Within the Statewide Wellness and Obesity Prevention Program grants; BF was one strategy that could be selected for funding and one funded agency used the Ounce of Prevention is Worth a Pound (Ounce) program to train health professionals on obesity prevention. Title V Director participated in cross agency work group to develop a State of Ohio agency lactation room policy. Obesity Coordinator will be invited to workgroup meetings.

Increase breastfeeding among Ohio's African Americans.
The WIC billboards promoting BF were displayed in African American communities. OIMRI CFHS program consultant will be invited to workgroup meetings.

Promote and support breastfeeding in WIC.
WIC billboards were erected and other media campaigns were held across the State of Ohio to promote BF to targeted populations. WIC Breastfeeding Peer Helper program will expand statewide.

Evaluate breastfeeding initiatives in WIC.
State Epidemiologist is conducting multi level analysis using PedNss data to evaluate Breastfeeding Peer Helper program.

c. Plan for the Coming Year

A. Support breastfeeding (BF) components of the Ohio Obesity Prevention Plan.

B. Support BF objectives of the Preventing Infant Mortality in Ohio: Task Force Report.

C. Promote and support breastfeeding throughout the State of Ohio.

D. Review BF data to identify targeted population and intervention for Ohio (eg. AA, Appalachians, teens, etc.)

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	50	92	99	99	99
Annual Indicator	98.8	90.2	92.2	92.6	92.6
Numerator	147117	136500	139550	138325	138325
Denominator	148903	151351	151353	149357	149357

Data Source				Universal Newborn Hearing Screening Data and Vital	Universal Newborn Hearing Screening Data and Vita
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	99	99	99	99	99

Notes - 2009
The 2009 data is currently not available, 2008 data was used as an estimate for 2009. The 2009 data will be finalized in the next BG application.

Notes - 2008
2008 data are not available; 2007 data are used as estimates

Notes - 2007
Data Source: Numerator: Universal Newborn Hearing Screening data; the actual percent of newborns screened before hospital discharge during Calendar Year 2007.
Ohio Vital Statistics birth data (2007 occurrent births).

a. Last Year's Accomplishments
The target for FY 2008 was ninety-nine percent (99%). For the reporting period, 1/01/2008 -- 12-30-2008, there were 149,357 births and of these, 138,325 received hearing screenings. The percentage of newborns screened was ninety-two point six (92.6%).

Monitor and provide technical assistance to birthing hospitals, children's hospitals, free-standing birthing centers and health departments to assure that infants receive hearing screenings and that referral rates are 4% or less statewide.

The ODH public health audiologists (2.9 FTEs) provided monitoring and oversight for Universal Newborn Hearing Screening (UNHS) programs and ensured compliance with UNHS legislation. They monitored hospital referrals and provide technical assistance. Hospital coordinators were contacted in January, 2009 and again in August, 2009 to emphasize complete and accurate data collection.

Hospitals submitted UNHS results to the Ohio Department of Health (ODH) electronically and by mail. Extracts of UNHS results and demographic information from IPHIS were imported into the updated Hi*Track database to capture all births in Ohio.

Connect auditory diagnostic evaluation information received by ODH with non-pass UNHS results to identify infants receiving hearing evaluations by three months of age; monitor tracking and follow-up of UNHS results to reduce the rate of loss to follow-up.

Pediatric Audiologists conducted follow-up diagnostic evaluations on infants not passing their newborn hearing screenings and sent the Reports to OHD where the consultant audiologists reviewed them. Reports were then sent to the RIHPs (Regional Infant Hearing Programs) for follow-up.

The RIHPs track all non pass referrals and provide early intervention services for infants identified with permanent childhood hearing loss and their families. Reports on the status of infants being served by the RIHPs, as of July, 2009, are monitored electronically on Hi*Track.

Increase diagnostic audiology services for infants by providing outreach to audiologists; by disseminating a directory of audiologists and audiology services; and by working collaboratively with audiology educators and providers to enhance/increase diagnostic sites.

ODH surveys pediatric audiologists providing follow-up services for non pass UNHS infants annually and maintains an electronic directory on the Help Me Grow website under Infant Hearing.

Increase public and professional awareness of early hearing detection and intervention (EHDI) by distributing educational materials to physicians, preparing/disseminating reports for legislators and others, identifying potential areas for collaboration and working with Au.D. programs and medical schools to incorporate EHDI into curriculums.

The Infant Hearing Program and the Genetics Program staff continued to explore ways to collaborate. In Fall 2009 the staff began to revise the UNHS Follow-up Hearing Evaluation Reporting form and genetics referral was included. A Genetics Counselor regularly attends HMG training to provide an overview of and literature on genetics. UNHS staff are active in the Region 4 Genetics Collaborative.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor and provide technical assistance to birthing hospitals, children's hospitals, free-standing birthing centers and health departments to assure that infants receive hearing screenings and that referral rates are 4% or less statewide.				X
2. Connect ODH auditory diagnostic evaluation information with non-pass UNHS results to identify infants receiving hearing evaluations by three months of age; monitor tracking and follow-up of UNHS results to reduce the rate of loss to follow-up.				X
3. Increase diagnostic audiology services for infants by providing outreach to audiologists; disseminating a directory of audiologists and services; and working collaboratively with audiology educators and providers to increase diagnostic sites.				X
4. Increase public/provider awareness of early hearing detection and intervention (EHDI) via educational materials; reports for legislators; identifying areas for collaboration; and working with medical schools to incorporate EHDI into curriculums.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A. The ODH public health audiologists (2.9 FTEs) continue to provide monitoring and oversight for Universal Newborn Hearing Screening (UNHS) programs and ensure compliance with UNHS legislation. They monitor hospital referral rates and provide technical assistance. Based on electronic reports received, hospital coordinators are periodically reminded to emphasize complete and accurate data collection, including alternate contact information.

B. Pediatric Audiologists conduct follow-up diagnostic evaluations on infants not passing their newborn hearing screenings. These are sent to OHD where the consultant audiologists review them and forward to the RIHPs (Regional Infant Hearing Programs) for follow-up. The RIHPs track non pass referrals and continue to provide early intervention services for infants identified with permanent childhood hearing loss.

C. ODH surveys pediatric audiologists providing follow-up services for non pass UNHS infants annually. The electronic directory is updated quarterly.

D. The Infant Hearing Program and the Genetics Program staffs continue to explore ways to collaborate with outside partners. In Fall, 2009 the staff revised the UNHS Follow-up Hearing Evaluation Reporting form to include a genetics referral as well a more closely following the format of the electronic records. A Genetics Counselor regularly attends HMG training to provide an overview of and literature on genetics.

c. Plan for the Coming Year

Continue to monitor and provide technical assistance to birthing hospitals, free standing birthing centers, children's hospitals, and local health departments to ensure that newborns receive hearing screenings and that referral rates are at or below 4%.

Activities

1. Assure continued hospital data reporting and regular extract of IPHIS data.
2. Review hospital UNHS data and provide feedback to hospitals.
3. Provide targeted Technical Assistance as needs are identified.
4. Monitor local health department compliance with UNHS requirements.

Continue to match audiologic diagnostic evaluations received by ODH to UNHS non-pass results to identify infants receiving a hearing evaluation by three months of age; monitor tracking and follow-up of infants with non-pass results to reduce numbers lost to follow-up.

Activities

1. Review and forward diagnostic audiology reports data for non-pass infants to RIHPs for data entry and electronic tracking.
2. Monitor tracking and follow-up processes in accordance with JCIH guidelines.
3. Provide technical support to RIHPs as need is identified.

Continue to promote awareness of the importance of early intervention and work collaboratively with professionals to provide early intervention (by age 6 months) for infants identified with a permanent childhood hearing loss.

Activities

1. Survey pediatric diagnostic audiologists annually and update directory.
2. Support SKI*HI training for RIHP service providers.
3. Prepare and disseminate Annual Report to Legislature and UNHS newsletter.
4. Continue outreach to pediatric audiologists and primary care providers.

Explore collaborative means of identifying program gaps and utilizing public and professional resources to assist in addressing identified program gaps.

Activities

1. Foster communication with the UNHS Advisory Subcommittee in order to identify and address program gaps, including loss to follow-up and funding for outreach initiatives and training.
2. Convene audiologists, professional groups, families, and other resources as needed to assist with program promotion, development of outreach, or creation of new materials.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7	7	7.5	7	7
Annual Indicator	8.0	6.6	7.1	7.1	7.2
Numerator	220006	182000	198000	198000	200000
Denominator	2765224	2754000	2787000	2787000	2771500
Data Source				Current Population Survey	Current Population Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	7	7	7	7	7

Notes - 2009
The 2009 data is provisional from the 2009 Annual Population Survey Report. We will finalize the 2009 data in the next FY.

Notes - 2008
2008 data are not available. 2007 data are used to estimate 2008 data.

Notes - 2007
CY 2007 data.

The Current Population Survey Annual Social and Economic Supplement (CPS – ASES) contains data on health insurance by state and age group. Data from the U.S. Census Bureau website (www.census.gov/hhes/www/cpstc/cps_table_creator.html) were used to construct the following table:

Ohio – Children Ages Birth Through 17 Years

Two- Year Average (2006 and 2007)

a. Last Year's Accomplishments
The target for CY 2009 was 7.0%. The actual percent of children without health insurance was 7.2%, slightly higher than reported for 2008 (7.0%). Ohio did not meet its target.

Monitor data regarding the rate of uninsured children.
This infrastructure level strategy was accomplished by calculating the rate of uninsured children in Ohio, which is 7.2% (the numerator is the two-year average, or 200,000 and the denominator is 2,771,500). Four percent of Ohio children were without medical insurance; however more than four times as many children (18.3%) were without dental insurance (2008 Ohio Family Health Survey (OFHS) and slightly more than 4% (6,917) of children receiving BCMH services had no health insurance. Detailed analyses of 2008 OFHS were conducted to assist in identifying areas with significant populations of uninsured, including insurance coverage of individuals with chronic diseases; insurance coverage for children with special health care needs and women; and coverage for vision, dental and hearing services.

Provide information, technical assistance, and training as appropriate to providers and consumers of DFCHS funded projects regarding how to assist families in accessing health insurance.
This population-based and infrastructure level strategy were accomplished by providing Information on how to apply for Medicaid/Healthy Start (HS) to all low-income families through 15 school-based dental sealant programs, 16 dental safety net programs; four dental OPTIONS programs; and 71 Child and Family Health Services subgrantees funded with ODH/MCH BG funds.
Critical Access Hospitals (CAH) in 34 rural communities, 150 Federally Qualified Health Center (FQHC) sites; and 40 Free Clinic sites worked to enroll children and families into Medicaid/HS Programs and to help providers and consumers understand and navigate the health care system.
The Ohio WIC program screened over 308,000 applicants to determine if the individual is on Medicaid/HS or is in need of a referral to the program via the interagency Combined Programs Application form.
BNS participated in a meeting with ODJFS to consider an option to implement Express Lane Eligibility which would allow ODJFS to accept other programs' income eligibility determination to meet the income requirements of Medicaid/HS.
The BCMH Eligibility Determination Process screens and refers who are potentially eligible for all applicable products of Medicaid, SSI, and Medicare.
BCMH staff provided training and technical assistance to PHNs and providers to assure comprehensive and efficient medical services to BCMH clients; Hospital Based Service Coordinators assisted families in coordinating medical care by specialists.

Promote enrollment in SCHIP (Healthy Start) expansion to 300% through public health agencies, schools and school-based programs (enabling level strategy).
Due to Ohio's budget deficit, the Medicaid expansion has been placed on hold; there are not enough funds to expand to the 300% level. The projected expansion was to provide coverage for an estimated 36,000 additional children.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Calculate the rate of uninsured children at the population and programmatic level using Census, OFHS and program data.				X
2. Provide information on applying for Medicaid/Healthy Start (HS) to all low-income families through DFCHS funded programs.		X		
3. Screen all Ohio WIC program applicants and participants to determine if the individual is on HS or is in need of a referral to the HS program via the interagency Combined Programs Application form.		X		
4. Screen and refer participants in the BCMH Eligibility Determination Process who are potentially eligible for all applicable products of Medicaid, SSI, and Medicare.		X		

5. Provide training and technical assistance to BCMH PHN staff to assure comprehensive and efficient medical services to BCMH clients.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Monitor data regarding the rate of uninsured children.

Infrastructure level strategy is being accomplished by reporting health insurance data from the National Current Population Survey, Ohio's Family Health Survey, and DFCHS programs; conducting analyses of OFHS data at the state and regional levels.

Provide information, technical assistance, and training as appropriate to providers and consumers of DFCHS funded projects regarding how to access and navigate the public health care system.

Population-based and infrastructure level strategy is being accomplished by DFCHS programs providing health insurance information to public/private providers; and implementing/monitoring the ODH/Medicaid Interagency Agreement (IA) containing provisions regarding Medicaid enrollment, outreach and training activities.

Promote enrollment in SCHIP (Healthy Start) expansion to 300% and other policy changes that lead to more kids/families being covered consistently and adequately (i.e. presumptive, continuous, express lane eligibility) through public health agencies, schools and school-based programs.

Enabling level strategy is being accomplished by providing information/updates regarding SCHIP expansion (Healthy Start) via trainings, conferences; establishing links to SCHIP expansion outreach activities via ODH website; and exploring paying premiums for SCHIP-eligible clients via BCMH.

c. Plan for the Coming Year
Monitor data regarding the rate of uninsured children.

This infrastructure level strategy will be accomplished by reporting data about the uninsured status from NCPS, OFHS, and DFCHS programs; conducting detailed analyses of the most current OFHS at the state and regional levels, by race and ethnicity; family income / FPL -- percentage, and source of health insurance (private / Medicaid / SCHIP / uninsured) to assist in identifying areas with significant populations of uninsured; and reporting how results of detailed analyses were used to benefit programs.

Provide information, technical assistance, and training as appropriate to providers and consumers of DFCHS funded projects regarding how to access and navigate the public health care system.

This population-based and infrastructure level strategy will be accomplished by providing health insurance information/materials to public and private sector providers, including child care health consultants, public health nurses, ODH subgrantees, general public, families of CSHCN, and parent advocacy groups via DFCHS programs; implementing and monitoring the ODH/Medicaid Interagency Agreement (IA) containing provisions regarding Medicaid enrollment, outreach and training activities; and promoting the use of Medicaid Administrative Claiming (MAC) in local health departments to improve access to Medicaid coverage and the use and delivery of

Medicaid-covered services.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		26.9	26.6	26.6	26.1
Annual Indicator	27.6	27.2	27.6	28.0	28.0
Numerator	31569	31010	32132	35003	35003
Denominator	114380	114008	116418	125011	125011
Data Source				CDC PedNSS	CDC PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	26.1	25.6	25.6	25.6	25.6

Notes - 2009
The 2009 data is currently not available. 2008 data has been used as an estimate for 2009.

Notes - 2008
Numerator: Number of children in Ohio WIC program in 2008, aged 2-5 years, who had BMI at or above the 85th percentile
Denominator:Total number of children aged 2-5 years in Ohio WIC program in 2008 for whom weight and height data were available.

Data Source: CDC PedNSS data for Ohio WIC program

Notes - 2007
Numerator: Number of children in Ohio WIC program in 2007, aged 2-5 years, who had BMI at or above the 85th percentile
Denominator:Total number of children aged 2-5 years in Ohio WIC program in 2007 for whom weight and height data were available.

Data Source: CDC PedNSS data for Ohio WIC program

a. Last Year's Accomplishments
Activities included continuing to update the statewide inventory, research options for creating a web based distribution of the inventory data base, and review of PEDNSS and Ohio BMI data. The inventory was updated via annual request for proposals (RFP) and the database for this information will continue to be kept up to date.

Researching options for a web based distribution of the inventory and the investigation into trends of childhood obesity using PEDNSS and Ohio BMI data was not completed. Efforts were instead

focused on the launch of the new WIC food packages.

The state WIC office assisted in bringing the American Dietetic Association Certificate in Child and Adolescent Weight Management Program to Cincinnati, Ohio September 4-6, 2008. Thirty-five WIC health professionals were in attendance and all passed the examination to be certified in child and adolescent weight management in October of 2008.

Activities included collaborating with the newly appointed ODH office of Healthy Ohio obesity coordinator and assist with collection of data for the 3rd grade BMI Sentinel School Sample. At this time the position of obesity coordinator has not been filled. In January a letter was sent to all WIC projects requesting their assistance with the 3rd grade BMI Sentinel School Sample. Many WIC health professionals and staff volunteered their time at local schools to assist with data collection.

Due to the launch of the new WIC food package on October 1, 2009, all efforts for program implementation were focused on participant education for the new foods. All projects were required to use these posters for three months at a time over the course of nine months. Posters focused on four topics: Breastfeeding, Whole Grains, Milk Choices, and Fruits and Vegetables. Samples of educational bulletin boards/posters are attached.

Activities included conducting the WIC participant survey and implementing the WIC Activity Box pilot. The participant survey was revised to gather more detailed information based upon VENA principles of customer service, questions regarding upcoming changes to the Authorized Foods List, ease of coupon use, and health behaviors and weight status. A summary of the findings is attached. In October of 2008, local WIC projects began piloting the Healthy Heroes Activity Boxes. Participants who were identified as 3-4 years of age and having a body mass index (BMI) at or above the 85th percentile were invited to participate. They were provided with a pre-test and activity box which included a DVD, coloring book, health/nutrition focused children's book, activity toy, and nutrition education. Follow-up was completed within three months of the initial visit where participant's weight status was reassessed and participants were provided with a post-test, health/nutrition focused children's book, activity toy, and additional nutrition education. The pilot ended on December 31, 2009 and at this time preliminary data is not yet available.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to update a statewide inventory, research options for creating a web based distribution and review of PEDNSS and Ohio BMI data.				X
2. Collaborate with ODH Office of Healthy Ohio to collect data for the 3rd grade BMI Sentinel School Sample.				X
3. Provide participant education on the new foods contained within the New WIC food package launched on October 1, 2009.				X
4. Conduct a WIC participant survey to gather more detailed information based upon VENA principles of customer service, questions regarding upcoming changes to the Authorized Foods List, ease of coupon use, and health behaviors and weight status.				X
5. Pilot the Healthy Heroes Activity Boxes and evaluate their impact.				X
6.				
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b. Current Activities

A. Inventory of statewide resources/programs (Infrastructure): Currently collecting data from subgrantees on all new and/or revised referral resources for overweight. Developing a web based distribution of the inventory (Infrastructure): Data based has been shared with the new Healthy Ohio Obesity Coordinator.WIC special project grant (Infrastructure): Not accomplished due to not obtaining the grant for this reporting year.

B. Value Enhanced Nutrition Assessment (VENA) and the new WIC food packages educational pieces (Infrastructure): Distributed educational pieces to local WIC staff based upon the Value Enhanced Nutrition Assessment (VENA) training and the new WIC food packages.

C. Virtual Obesity Team: No longer functioning
3rd grade BMI State and County School Sample (Infrastructure): Currently assisting with data collection on the 3rd grade BMI State and County School Sample.

D. Evidence based programs (Infrastructure): Exploring the use of focus groups on participant's use of the fruit and vegetable cash voucher.

E. WIC participant survey (Infrastructure): Revising the survey to include additional questions on weight gain during and after pregnancy, revise questions addressing perception of childhood weight and healthy eating behaviors. Analyze the WIC Activity Box Pilot Data (Infrastructure): reviewing data to inform the next phase for the WIC Activity Box pilot.

c. Plan for the Coming Year

Conduct data surveillance and monitoring activities.
1. Continue to conduct and support the inventory of statewide resources/programs addressing the treatment of childhood obesity (Obesity Inventory Tool) as necessary through WIC clinics, CFHS projects, and Rural Health programs.
2. Work with the ODH office of Healthy Ohio in using the inventory data.
3. Analyze data from the WIC participant survey
4. Assist as needed on the ODH Obesity Report.

Increase WIC staff education and involvement in prevention and treatment initiatives.
1. Continue to distribute educational pieces on topics such as cultural competency and critical thinking to local WIC staff to continue the foundation established with the Value Enhanced Nutrition Assessment (VENA) training.
2. Provide advanced education topics to staff related to the new food package implementation.

Explore new opportunities for collaboration.
1. Continue collaboration with the ODH office of Healthy Ohio obesity coordinator to support the state obesity plan.
2. Continue to serve, as needed, on the Ohio American Academy of Pediatrics advisory committee for the Ounce of Prevention promotion grant.
3. Seek for partnership and collaboration opportunities by serving on the Supplemental Nutrition Assistance Program for Education committee for partnership, information and education resources.

Investigate evidence based interventions for the WIC population age 2 to 5 years.
1. Explore the creation of a WIC Obesity Taskforce using local WIC health professional staff to help select potential evidence based program(s) to implement.

Evaluate WIC efforts to impact overweight
1. Continue to reevaluate the WIC participant survey to gather data on participant perception of weight, WIC obesity intervention and healthy eating behavior.
2. Begin the planning process for the next phase of the "WIC Activity Box" Pilot aimed to provide education to participants who are at-risk for overweight or are obese.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		18.5	19	14	14
Annual Indicator	20.9	15.3	15.9	19.2	19.2
Numerator	31111	23058	23295	28363	28363
Denominator	148855	150510	146739	147410	147410
Data Source				Ohio Vital Statistics	Ohio vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	14	14	14	14	14

Notes - 2009
The 2009 data is currently not available. 2008 data has been used as as estimate for 2009.

Notes - 2008
2008 data are not available. Data from 2007 were used to estimate 2008.

Notes - 2007
Data Source: 2007 Vital Statistics birth records - resident births.

a. Last Year's Accomplishments
Expand Ohio Partners for Smoke-Free Families 5 A's evidence-based systems-level approach for treating tobacco use and dependence in/with ODH funded systems of care (i.e., WIC, Ohio Infant Mortality Reduction Initiative, Family Planning.

BCFHS Perinatal Smoking Cessation Program (PSCP) and the Bureau of Nutrition Services secured $50,000 from the WIC Program Operational Adjustment Project to expand the Ohio Partners for Smoke-Free Families WIC initiative. 26 WIC sites from 17 Ohio counties were recruited. PSCP assessed all sites to determine their capacity to provide smoking cessation interventions and their current or existing smoking cessation services
5 A's quality improvement strategies were developed and implemented at each WIC site. PSCP provided smoking cessation materials, training and technical assistance.

Process data collection procedures were implemented and outcome data collection procedures are being developed.

Build an Ohio Partnership to address tobacco use and cessation among women of reproductive age, including pregnant women.

As an ongoing effort to reduce infant mortality/poor pregnancy outcomes state and local partners are bringing together their resources to address tobacco use among women of reproductive age, including pregnant women. PSCP actively participated in the development of the Ohio Comprehensive Tobacco Use Prevention Strategic Plan, December 2008; and the development of recommendations and strategies found in the Preventing Infant Mortality in Ohio Task Force Report 2009.

Incorporate culturally appropriate activities and interventions. Refer to activities in State Performance Measure 04.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Expand Ohio Partners for Smoke-Free Families 5 A's evidence-based systems-level approach for treating tobacco use and dependence in/with ODH funded systems of care.				X
2. Build an Ohio Partnership to address tobacco use and cessation among women of reproductive age, including pregnant women.				X
3. Incorporate culturally appropriate activities and interventions.				X
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b. Current Activities

A. Expand Ohio Partners for Smoke-Free Families 5 A's evidence-based systems-level approach for treating tobacco use and dependence in/with ODH funded systems of care (i.e., WIC, Ohio Infant Mortality Reduction Initiative, Family Planning).

This infrastructure-level strategy will be accomplished through the following activities:
1. Implement provider/system-level quality improvement strategies and provide the tools, training and technical assistance needed to treat pregnant and postpartum smokers.
2. Implement process data collection procedures.
3. Test the provider/system-level quality improvement strategies and measure compliance.
4. Conduct a process evaluation.

B. Engage state partners to address tobacco use and cessation among women of reproductive age, including pregnant women as an ongoing effort to reduce infant mortality/poor pregnancy outcomes.

This infrastructure-level strategy will be accomplished through the following activities:
1. Identify and recruit public and private partners.
2. Assist Director of Health convene an Infant Mortality Task Force and develop recommendations to address infant mortality and disparities in Ohio.

3. Establish tobacco use and cessation among women of reproductive age, especially pregnant women as a vital component to a comprehensive plan addressing infant mortality and disparities in Ohio.

C. Incorporate culturally appropriate activities and interventions-refer to activities in State Performance Measure 04.

c. Plan for the Coming Year

Build the capacity of MCH healthcare systems to support the 5 A's evidence-based smoking cessation intervention and assist MCH practitioners integrate the 5 steps Ask-Advise-Assess-Assist-Arrange as a standard of care (USPHS Treating Tobacco Use and Dependence Guidelines).

Ohio Partners for Smoke-Free Families will accomplish this through the following activities: Assess the MCH healthcare systems (i.e., WIC, CFHS) capacity to support evidence-based smoking cessation intervention; assess provider (i.e., WIC, CFHS) awareness of evidence-based smoking cessation interventions; ensure that healthcare systems are in place to screen women for tobacco use and offer treatment; ensure that practitioners have the tools, training and technical assistance needed to treat smokers effectively; and ensure women have access to information that will help them take action to quit smoking. (i.e., Promote Healthy Lives Pledge) Build the capacity of CFHS healthcare providers to address environmental health issues during pregnancy, including exposure to second and third-hand smoke.

Child and Family Health Services will accomplish this through the following activities: Assess the healthcare systems (i.e., CFHS) capacity to support environmental health risk reduction; assess provider (i.e., CFHS) awareness of environmental health risks; ensure that systems are in place to screen women for environmental health risks; ensure that practitioners have the tools, training and technical assistance; and ensure women have access to information that will help them take action to reduce environmental exposures.

Engage partners to address tobacco use and dependence among women of reproductive age, including pregnant women.

The Perinatal Smoking Cessation Program will accomplish this through the following activities: Promote evidence-based smoking cessation interventions; collaborate with partners and leverage resource; use the media effectively; convene and facilitate or participate in the following workgroups to address tobacco use and dependence: The Infant Mortality Consortium; The Ohio Comprehensive Tobacco Use and Prevention Strategic Plan-Women of Reproductive Health Workgroup; MCH Block Grant Performance Measure 15 Workgroup, The Ohio Tobacco Control and Resource Group and Ohio Partners for Birth Defects Prevention.

Incorporate culturally appropriate activities and interventions-refer to activities in State Performance Measure 04.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	5	5	8.5	8.5	7

Annual Indicator	9.1	8.7	7.5	10.3	10.3
Numerator	74	71	61	83	83
Denominator	816936	813186	811659	809174	809174
Data Source				Ohio Vital Statistics	Ohio Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	7	7	7	7	7

Notes - 2009
The 2009 data is currently not available. 2008 data has been used as an estimate for 2009.

Notes - 2008
2008 data are not available. 2007 data are used to estimate 2008 data.

Notes - 2007
Numerator: Ohio Vital Statistics 2007 final death file
Denominator: U.S. Census/NCHS Bridged Race, Vintage 2007 Ohio population estimates for 2007

a. Last Year's Accomplishments
Use data, including Child Fatality Review, Youth Risk Behavior Survey, Vital Statistics and Ohio Hospital Data, to describe problems of youth suicide in Ohio, and then share results with state and county partners, including but not limited to DCFHS funded grants that work with teens and the Ohio Department of Mental Health.

This infrastructure level strategy was accomplished by distributing on-line, reports that include youth suicide data.

Provide information to health care providers, educators and others who interact directly with children and youth in the identification of mental health issues.

This population based and infrastructure level strategy was accomplished by the development of a report on teen suicide and mental health issues targeted to those who interact directly with children and youth. Local CFR boards reviewed 37 deaths to children from suicide in 2007. These represent 12 percent of all reviews for children ages 10-27. Eight of the 37 reviews for suicide deaths indicated the child had a history of child abuse or neglect.

Collaborate with state and county partners, including but not limited to the ODMH and the CFR Board, and share state wide strategies.

This infrastructure level strategy was accomplished by collaborating the Ohio Suicide Prevention Foundation Advisory Committee, the Child Fatality Review Board, and county suicide prevention coalitions. A report on Adolescent Suicide and Self-Inflicted Injury in Ohio is under development. CFR findings for the past year were shared with county suicide prevention coalitions and task forces to focus on awareness of suicide and develop strategies to reduce the factors that increase the risk of suicide, identify youth at risk and increase the availability of mental health

services. Data from the CFR Annual Report were shared through the following venues: CFR trainings; a report-release announcement; conferences; CFR advisory committee which includes representation from the ODMH. The report was published on the ODH Website and published copies distributed to mandated elected officials, local CFR boards, Family and Children First Councils and the State Library system.

ODH continues to collaborate with the Ohio Suicide Prevention Foundation (OSPF) Advisory Committee and the Ohio Department of Mental Health. In September 2009, ODH (Violence and Injury Prevention Program and the Data Center jointly) was awarded a 4-year grant of $273,727/year from the CDC to develop a new violent death surveillance system and become the 18th state participant in the National Violent Death Reporting System (NVDRS).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Use data, including CFR, YRBS, VS and Ohio Hospital Data, to describe youth suicide in Ohio, and share results with state/county partners that work with teens and the Ohio Department of Mental Health.				X
2. Provide information to health care providers, educators and others who interact directly with children/youth in identifying mental health issues.				X
3. Collaborate with state and county partners, including but not limited to the ODMH and the CFR Board, and share state wide strategies.				X
4.				
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b. Current Activities

Explore available data sources to describe problems of youth suicide in Ohio, and share results with partners. Infrastructure strategy focused on prescription drug abuse and deaths related to issue. A report, "EPIDEMIC OF PRESCRIPTION DRUG OVERDOSE IN OHIO" was developed. Support and feedback is being provided to ODH's injury Prevention Program as recommendations are developed to address the issues revealed in document as drug overdose in teens is one method of suicide.

Provide information to health care providers, educators and others who interact directly with children and youth in the identification of mental health issues and risk factors for youth suicide. Infrastructure level strategy is not able to complete fact sheets as proposed specific to teen suicide as Ohio did not obtain weighted data for the 2009 YRBS. Information on recognizing mental health issues in students was presented to school nurses during 2009 school nurse regional conferences.

Collaborate with state and county partners, including but not limited to the Ohio Department of Mental Health, Office of Healthy Ohioans and the Child Fatality Review Board, and share state wide strategies to reduce youth suicide. Infrastructure level strategy is accomplished by collaborating with program areas and respective agencies and county suicide prevention coalitions, on quarterly basis in conjunction with injury prevention task force to share ideas and

strategies that will promote the work of reducing teen suicide.

c. Plan for the Coming Year
Review data, including Child Fatality Review, Youth Risk Behavior Survey, Vital Statistics and Ohio Hospital Data, to describe problems of youth suicide in Ohio, and disseminate results with state and county partners, including but not limited to DCFHS funded grants that work with teens and the Ohio Department of Mental Health.

Provide information to health care providers, educators and others who interact directly with children and youth in the identification of mental health issues.

Collaborate with state and county partners, including but not limited to the Ohio Department of Mental Health and the Child Fatality Review Board, and share state wide strategies.

Conduct 2011 YRBS in Ohio schools.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	74	74	74	74	74
Annual Indicator	68.5	67.4	69.8	69.3	69.3
Numerator	1633	1642	1779	1659	1659
Denominator	2385	2437	2550	2393	2393
Data Source				Ohio Vital Statistics	Ohio Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	74	74	74	74	74

Notes - 2009
The 2009 data is currently not available. 2008 data has been used as en estimate for 2009.

Notes - 2008
2008 data are not available. 2007 data are used as an estimate for 2008.

Notes - 2007
Data Source: 2007 Vital Statistics birth records - resident births.

a. Last Year's Accomplishments
Continue the analysis and identify trends of data pertaining to birth outcomes by hospital level and/or regional perinatal designation to inform the design and delivery of services to improve access to risk-appropriate facilities.

Reorganization of the new data center resulted in this project being combined into a cross-cutting project of the data center that encompasses community profiles. The community profiles are being developed but are still in the planning stage. PRAMS data was reweighted with this project in mind, but the PRAMS sample size was too small for this to be informative.

Fund, monitor and evaluate the Regional Perinatal Center program.

Provided funding and ongoing technical assistance to six (6) Regional Perinatal Center programs. Each Regional Perinatal Center participated in the Ohio Perinatal Quality Collaborative work and produced an Urban Project.

Facilitate process to complete results-based accountability model developed by Mark Friedman to produce performance measures and future interventions.

See State Performance Measure 2 (B).

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue the analysis and identify trends of data pertaining to birth outcomes by hospital level and/or regional perinatal.				X
2. Fund, monitor and evaluate the Regional Perinatal Center program.				X
3. Facilitate process to complete results-based accountability model.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continue the analysis and identify trends of data pertaining to birth outcomes by hospital level and/or regional perinatal designation to inform the design and delivery of services to improve access to risk-appropriate facilities.
This infrastructure-level strategy will be accomplished by:

1. developing automated monthly regional perinatal report that include information about preterm birth and the percent of babies by birthweight born in hospital identified by level designation;
2. disseminating regional profile reports to Birth Outcomes workgroup members and regional perinatal center teams;
3. planning a project that would: a) identify 2 regions with the highest percentage of VLBW babies born in level I facilities: and, b) perform descriptive analyses to identify the characteristics of VLBW infants who are born in level I facilities in these regions in order to identify why VLBW infants are born in the Level I facilities; and
4. reweighting PRAMS data by perinatal region and sharing that information with stakeholders in those regions.

Fund, monitor and evaluate the Regional Perinatal Center program.
This infrastructure-level strategy will be accomplished by:

1. implementing an interagency agreement with ODJFS for work with the Ohio Perinatal Quality Collaborative
2. working with RPCs and local urban health departments to plan and implement RPC Urban Project.

c. Plan for the Coming Year

Continue the analysis and identify trends of data pertaining to birth outcomes by hospital level and/or regional perinatal designation to inform the design and delivery of services to improve access to risk-appropriate facilities.

This infrastructure-level strategy will be accomplished by: 1) developing web-based regional perinatal reports that include information about preterm birth and the percent of babies by birthweight born in hospital identified by level designation; 2) disseminating regional profile reports to DCFHS staff; and 3) continue to plan a project that would: a) identify 2 regions with the highest percentage of VLBW babies born in level I facilities: and, b) perform descriptive analyses to identify the characteristics of VLBW infants who are born in level I facilities in these regions in order to identify why VLBW infants are born in the Level I facilities.

Fund, monitor and evaluate DCFHS programs designed to take data to action.

This infrastructure-level strategy will be accomplished by: 1) strengthen partnership with ODJFS to implement quality improvement activities among local maternal and child health providers and 2) align DCFHS programs to implement the recommendations identified in Preventing Infant Mortality in Ohio: Task Force Report.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	88.5	88.5	88.5	80.5	80.5
Annual Indicator	87.2	72.7	70.7	69.7	69.7
Numerator	122663	80972	82438	77693	77693
Denominator	140748	111416	116582	111478	111478
Data Source				Ohio Vital Statistics	Ohio Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	80.5	80.5	80.5	80.5	80.5

Notes - 2009

The 2009 data is currently not available. 2008 data has been used as an estimate for 2009.

Notes - 2008
2008 data not available; 2007 data are used as estimates.

Notes - 2007
Data Source: 2007 Vital Statistics birth records - resident births.

a. Last Year's Accomplishments
Analyze BCFHS Family Planning referral data to prenatal care for women with positive pregnancy tests. Identify trends, opportunities for technical assistance and/or intervention and recommend follow-up activities.

This infrastructure level strategy was accomplished by analyzing prenatal referral data by race and by agency for all clients with a positive pregnancy test. A small number of agencies were identified as needing TA due to not properly documenting referrals for prenatal care.

Examine disparities in prenatal care in first trimester rates in regards to age, marital status, income, education, parity, payer, race and ethnicity.

This infrastructure level strategy was accomplished by collaborating with faith based and social service organizations, local public health agency and The Ohio State University to hold "Complex Conception: A Conference on Race, Class and Healthy Birth Outcomes" in June 2009. ODH arranged for Dr. Camara P. Jones of the CDC to present on health equity and disparities at the Ohio Public Health Epidemiology Symposium and at ODH; collaborating with Columbus Public Health in the Action Learning Collaborative: Partnership to Eliminate Disparities in Infant Mortality, a national project which aims to decrease racial disparities in infant mortality in US urban areas; examining birth outcome disparities as part of the work of the Ohio Infant Mortality Task Force, which helped to develop the 10 recommendations presented to the Governor in September 2009.

Provide training and/or technical assistance to increase strategic plans to increase cultural competency in family planning and prenatal care services in DFCHS funded programs.

See National Performance Measure #18 (B)

Facilitate process to complete results-based accountability model developed by Mark Friedman to produce performance measures and future interventions.

See State Performance Measure 2 (B).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Analyze BCFHS Family Planning referral data to prenatal care for women with positive pregnancy tests.				X
2. Examine disparities in prenatal care in first trimester rates.				X
3. Provide training and/or technical assistance to increase strategic plans to increase cultural competency in family planning and prenatal care services in DFCHS funded programs.				X
4. Facilitate process to complete results-based accountability model.				X
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
Analyze BCFHS FP referral data to prenatal care for women with positive pregnancy tests. Identify opportunities for technical assistance.

Infrastructure level strategy is being accomplished by analyzing FP referral data for intendedness, perinatal depression/mental health; developing reports that outline opportunities for TA and/or QI; identifying pre/interconception (P/IC) service protocols for public/private providers; and using focus group results of women of childbearing age and providers re: P/IC to inform design/delivery of health education messages.

Examine disparities in prenatal care in first trimester rates.

Infrastructure level strategy is being accomplished by analyzing data about first trimester entry into prenatal care by age, marital status, income, education, parity, payer, race and ethnicity; reviewing literature of evidence-based practices on getting women into prenatal care; and providing TA to strengthen referral and follow-up between FP and prenatal care services; and to ensure education to women about the importance of early entry into prenatal care.

Provide training and/or TA to increase cultural competency in family planning and prenatal care services in DFCHS funded programs.

See SPM 4.

Support the work of the Infant Mortality (IM) Consortium.

Infrastructure-level strategy is being accomplished by implementing QI activities among MCH providers; and aligning DCFHS programs to implement the IM Task Force recommendations.

c. Plan for the Coming Year
Analyze BCFHS Family Planning referral data to prenatal care for women with positive pregnancy tests. Identify trends, opportunities for technical assistance and/or intervention and recommend follow-up activities.

This infrastructure-level strategy will be accomplished by analyzing FP referral data including chart audits, FP data, other qualitative data to see if it varies by intendedness, perinatal depression/mental health; developing report based on analysis that identifies trends and opportunities for technical assistance and/or quality improvement recommendations; identifying opportunities to implement pre/interconception service protocols for public health and private providers within ODH; and using focus group results of women of childbearing age and providers of WCA women of childbearing age re: pre/interconception care (P/IC) to inform design/delivery of health education messages interventions and align DCFHS programs to promote those messages.

Examine disparities in prenatal care in first trimester rates in regards to age, marital status, income, education, parity, payer, race and ethnicity.

This infrastructure-level strategy will be accomplished by gathering and analyzing data about first trimester entry into prenatal care in BCFHS funded programs by age, marital status, income,

education, parity, payer, race and ethnicity; reviewing literature of evidence-based practices on getting women into prenatal care in the first trimester; and providing technical assistance to BCFHS funded programs to strengthen referral and follow-up to activities between family planning services and prenatal care services and to ensure education to women about the importance of early entry into prenatal care based on data.

Provide training and/or technical assistance to increase strategic plans to increase cultural competency in family planning and prenatal care services in DFCHS funded programs.

This infrastructure-level strategy will be accomplished by working with SPM 4 Workgroup. See SPM 4 work plan.

Support the work of the consortium which formed as a result of the Preventing Infant Mortality in Ohio: Task Force Report.

This infrastructure-level strategy will be accomplished by strengthening partnership with ODJFS to implement quality improvement activities among local maternal and child health providers; and aligning DCFHS programs to implement the recommendations identified in Preventing Infant Mortality in Ohio: Task Force Report.

D. State Performance Measures

State Performance Measure 1: *Increase statewide capacity to reduce unintended pregnancies among populations at high risk for poor birth outcomes.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		2	3	3	4
Annual Indicator		1	2	2	2
Numerator		1	2	2	2
Denominator	4	4	4	4	4
Data Source				Program Benc	Program Benc
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	4	4	4	4	

Notes - 2009
The 2009 data is currently not available 2008 data was used as an estimate for 2009.

Notes - 2008
Progress for this process measure is measured by the extent to which four benchmarks can be reached. The target for FFY 2008 was to reach three of these benchmarks: 1) Identify baseline rates of unintended pregnancy rates in Ohio; 2) identify populations and areas at risk for poor birth outcomes; and 3) identify and apply appropriate evidence-based practice standards and interventions for the target population. Ohio has met benchmarks 2 and 3.

Notes - 2007
Progress for this process measure is measured by the extent to which four benchmarks can be reached. The target for FFY Year 2007 was to reach three of these benchmarks: 1) identify

baseline rates of unintended pregnancy rates in Ohio; 2) identify populations and areas at risk for poor birth outcomes; and 3) identify and apply appropriate evidenced-based practice standards and interventions for the target population. Ohio has met benchmarks 2 and 3 and has made progress toward #1 through analysis of PRAMS data.

a. Last Year's Accomplishments
Examine disparities in pregnancy rates in regards to age, relationship status, income, education, race and ethnicity.

ODH program compared rates of unintended and unwanted pregnancies among diverse groups using family planning program data, PRAMS data, and vital statistics. Information regarding pregnancy intention is included in discussions with funded entities during site visits.

ODH has convened as task force "Preventing Infant Mortality in Ohio". A report from this task force includes the following recommendations that address reproductive health and poor birth outcomes: (1) provide comprehensive reproductive health services and service coordination for all women and children before, during and after pregnancy; (2)implement health promotion and education to reduce preterm birth; (3) address the effects of racism and the impact of racism on infant mortality; and (4) increase public awareness on the effect of preconception health on birth outcomes.

Work with Ohio Medicaid to establish a family planning Medicaid waiver.

BCFHS collaborated with Ohio Medicaid to review and revise all Medicaid family planning CPT codes. This effort was in preparation to the application for a family planning Medicaid waiver. The governor's office has indicated that Ohio will apply for a Medicaid family planning waiver during the first quarter of 2010. There is some thought that the health reform bill currently in Congress may make this waiver unnecessary as the proposal for health reform will cover all patients at or below 150% of the federal poverty level. Still in progress.

Improve ODH subsidized family planning programs.

Program has requested that the three family planning programs be merged into one grant program. This will be accomplished by July 1, 2011, at which time a competitive grant application process will be completed. This RFP will be prioritized to provide services among populations at highest risk for poor birth outcomes. This will also enable all family planning programs to access the 340B Drug Pricing Program and the Prime Vendor Program, bringing savings of contraceptives and medical supplies to all projects. By July 1, 2011, all ODH supported family planning programs will have the same requirements, and the same review and evaluation processes.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Examine disparities in pregnancy rates in regards to age, relationship status, income, education, race and ethnicity.				X
2. Work with Ohio Medicaid to establish a family planning Medicaid waiver.				X
3. Improve ODH subsidized family planning programs.				X
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

Examine disparities in pregnancy rates in regards to age, relationship status, income, education and race and ethnicity. Infrastructure level strategy is being accomplished by analyzing family planning and PRAMS to examine rates of unintended and unwanted pregnancies among diverse groups; examining risk levels for black women for poor birth outcomes; and reviewing priorities for funding preconception/interconception services for diverse population groups.

Work with Ohio's Medicaid program to expand eligibility for family planning services to uninsured men and women aged 18-55 with incomes at or below 200% of the Federal Poverty Level (FPL). Infrastructure level strategy is being accomplished by working with ODJFS and Waiver workgroup to complete application to CMS for waiver.

Assess progress in assuring that ODH funded family planning programs provide culturally and linguistically appropriate services (CLAS). Infrastructure level strategy is being accomplished by providing CLAS tool for all grant applicants.

c. Plan for the Coming Year

Reduce disparities in pregnancy rates in regards to age, relationship status, income, education and race and ethnicity. Infrastructure level strategy will be accomplished by mapping state using reproductive health and social indicators to determine priority for family planning funding; establishing priorities for funding family planning services; and revising ODH funding family planning project to include all funding sources.

Work with Ohio's Medicaid program to expand eligibility for family planning services to uninsured men and women aged 18-55 with incomes at or below 200% of the Federal Poverty Level (FPL). Infrastructure level strategy will be accomplished by working with Medicaid and other coalition partners to expand Medicaid eligibility to clients at or below 200% of FPL

Assess progress in assuring that ODH funded family planning programs provide culturally and linguistically appropriate services (CLAS). Infrastructure level strategy will be accomplished by providing CLAS training (via United Way) for all ODH funded family planning providers.

State Performance Measure 2: *Percent of low birth weight black births among all live black births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		13.4	13.3	13.2	13.1
Annual Indicator	13.6	14.2	16.2	16.4	16.4
Numerator	3278	3615	3603	3683	3683
Denominator	24116	25494	22296	22408	22408
Data Source				Ohio Vital Statistics	Ohio Vital Statistics
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	13	13	13	13	

Notes - 2008
2008 Vital Statistics birth data are not available; 2007 data are used as estimates.

Notes - 2007
Data Source: 2007 Vital Statistics birth records - resident births.

a. Last Year's Accomplishments
Survey DFCHS programs interacting with women of childbearing age to determine if services are provided to population of greatest risk according to PPOR data. Utilize data to determine future policy and funding direction.

13 OIMRI funded and monitored programs with a focus on African American populations at greatest risk of poor birth outcomes. Pre/interconception content has been included in the OIMRI applications.

Facilitate process to complete results-based accountability model developed by Mark Friedman to produce performance measures and future interventions.

Because of reorganization of home visiting programs within the Ohio Department of Health, this project was not completed.

Continue to strengthen breastfeeding protection, promotion and support within the Ohio Infant Mortality Reduction Initiative (OIMRI) program.

OIMRI program has worked to heighten and promote awareness of breastfeeding protection information and practices, relative to preventing infant mortality, among the 13 funded programs. One community health worker was trained as a peer counselor has presented information at the Ohio Community Health Workers Association.

Collaborate with internal partners e.g., the Bureau of Oral Health Services, the Office of Ohio Health Equity, Help Me Grow, Bureau of Prevention, etc. to address eliminating the disparity of infant mortality.

Collaborated with faith based and social service organizations, local public health agency and The Ohio State University to hold "Complex Conception: A Conference on Race, Class and Healthy Birth Outcomes" in June 2009. ODH arranged for Dr. Camara P. Jones of the CDC to present on health equity and disparities at the Ohio Public Health Epidemiology Symposium and in a small group with the BCFHS staff. ODH collaborated with Columbus Public Health in participation of Partnership to Eliminate Disparities in Infant Mortality, a national project which aims to decrease racial disparities in infant mortality in US urban areas. ODH extensively examined birth outcome disparities as part of the work of the Ohio Infant Mortality Task Force. The practical input helped to develop the 10 recommendations that were presented to the Governor in September 2009.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Survey DFCHS programs interacting with women of childbearing age to determine if services are provided to population of greatest risk.				X
2. Facilitate process to complete results-based accountability model.				X
3. Continue to strengthen breastfeeding protection, promotion				X

and support within the OIMRI program.				
4. Collaborate with internal to address eliminating the disparity of infant mortality.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Analyze and implement statewide recommendations of Ohio IMTF. Infrastructure level strategy will be implemented by supporting and/or integrating recommendations into new/existing ODH efforts to address IM and disparities.

Provide TA to DFCHS programs interacting with women of childbearing age to assure services are provided to population of greatest risk. Utilize data (PPOR) to determine future policy/funding direction. Infrastructure-level strategy will be accomplished by updating PPOR data; improving linkage of VS data to program data; reviewing populations of greatest risk for women of childbearing age in CFHS CHA; continuing work on data system for OIMRI, including working with Florida State University on a home visiting evaluation project; funding/monitoring 13 OIMRI programs; exploring ideas to increase AA response rates in PRAMS; and adding PCC/ICC content to DCFHS home visiting programs.

Strengthen breastfeeding protection, promotion and support within OIMRI program. Infrastructure-level strategy will be accomplished by evaluating impact of breastfeeding training on OIMRI staff; strengthen breastfeeding training for CHWs; and exploring cross program coordination in 1 county.

Collaborate with partners to eliminate disparities in infant mortality. Infrastructure-level strategy will be accomplished by working with ODH Data Center to develop statewide mapping capacity; and identifying new opportunities in eliminating disparities in IM.

c. Plan for the Coming Year
Collaborate with the Ohio Infant Mortality Consortium to implement statewide recommendations of the Ohio IMTF, specifically those recommendations targeting racism and disparities. Infrastructure level strategy will be implemented by supporting and/or integrating recommendations into new and existing ODH efforts to address infant mortality and disparities.

Engage other ODH partners whose programs impact maternal and child health to develop and fund a social marketing campaign to reduce low birth weight births. Infrastructure-level strategy will be accomplished by facilitating the collaboration of multiple ODH MCH serving programs to develop, fund and implement a social marketing campaign focused on prenatal smoking cessation, gestational diabetes and fetal alcohol spectrum disorder.

Incorporate activities from the Gestational Diabetes Mellitus (GDM) and Chronic Disease Integration Project into the Ohio Infant Mortality Reduction Initiative (OIMRI) program. Infrastructure-level strategy will be accomplished by identifying appropriate activities from the GDM and CD Integration Project that can be delivered by community health workers funded through the OIMRI program.

State Performance Measure 3: *Increase the capacity of the State to assess social/emotional health needs of MCH populations and to promote early identification, prevention and intervention services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		1	3	3	4
Annual Indicator		1	1	2	2
Numerator		1	1	2	2
Denominator	4	4	4	4	4
Data Source				Program benc	Program Benc
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	4	4	4	4	

Notes - 2009
The 2009 data is currently not available, 2008 data was used as an estimate. This SPM is being discontinued.

Notes - 2008
Progress for this process measure is measured by the extent to which 4 benchmarks can be reached. The target for FFY 08 was: 1) assess social/emotional health needs of MCH populations; 2) develop mechanisms to promote early identification of social/emotional health needs of MCH populations; 3) develop prevention services for MCH populations at risk. Ohio has made some progress toward meeting these targets.

Notes - 2007
Progress for this process measure will be measured by the extent to which 4 benchmarks can be reached. The target for FFY 07 was 1) assess social/emotional health needs of MCH populations; 2) develop mechanisms to promote early identification of social/emotional health needs of MCH populations; 3) develop prevention services for MCH populations at risk. Ohio has made some progress toward meeting these targets.

a. Last Year's Accomplishments
Strategy 1 (Identification): Examine data being collected within Ohio's Help Me Grow program and NASHP pilot study for the past 12 months on the prevalence of (a) physicians and (b) Help Me Grow home visitors using social-emotional screening tools.

Strategy 2 (Prevention): Calculate the number of individuals who have been trained throughout the state on the Ages and Stages: Social Emotional screening tool who are (a) physicians, (b) clinicians other than MDs, (c) child care providers, (d) Help Me Grow staff, and (e) pre-school teachers.

Strategy 3 (Intervention): Conduct focus groups with the state's new 168 mental health consultants to find out the extent to which children birth to age 8 are being referred for further evaluation of their social emotional health needs. Additionally, this data will be compared to what we would expect the referral rates to be based on the programs using a screening tool.

Final Report for the Time Period of October 1, 2008 to September 30, 2009

Over 400 physicians have been trained in the state of Ohio to conduct developmental screenings on children using the Ages and Stages Questionnaire, Ages and Stages Questionnaire: Social Emotional, and the Modified Checklist for Autism for Toddlers (M-CHAT).

All Help Me Grow service coordinators and home visitors (approximately 2,000) are currently required to use the ASQ and the ASQ: SE at intake within the first 45 days of referral for the children in our Home Visitation program. These home visitors and service coordinators are also required to re-screen children using these two tools every 4 to 6 months as needed, or more often when they or the child's parent(s) have a concern.

Child care providers are being trained as well and to date, Healthy Child Care Ohio has trained over 300 child care providers in how to conduct ASQ: SE.

In strategy 3, we said that we would calculate the number of pre-school teachers and early childhood mental health consultants. An effort is underway to do this count, but the count has been delayed for several reasons. First, Help Me Grow has been able to put their ASQ:SE training online so that it can be accessed at any time by persons working within Help Me Grow. Second, there are a number of projects (National Association of State Health Policy (NASHP), Autism Education Pilot, and CHIPRA) which continue to teach screening procedures to medical professionals throughout the state and the numbers change almost daily. We do not yet know to what extent pre-school teachers have started administering social-emotional screenings to young children. Finally, Early Childhood Mental Health Consultants are on the receiving end of referrals coming from screenings which show a concern in the area of social-emotional development, but the extent to which they are administering the ASQ: SE is not yet known.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Examine data being collected within Ohio's Help Me Grow program and NASHP pilot study for the past 12 months on the prevalence of a) physicians and b) Help Me Grow home visitors using social-emotional screening tools.				X
2. Conduct focus groups with mental health staff to determine extent children (0-8) are referred for evaluation of their social emotional health needs. Data will be compared to expectations for referral rates in programs using a screening tool.				X
3. Calculate number of individuals trained throughout the state on the Ages and Stages: Social Emotional screening tool who are a) physicians, b) clinicians other than MDs, c) child care providers, d) Help Me Grow staff, and e) pre-school teachers.				X
4.				
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b. Current Activities

In 2010 and 2011, Ohio will continue to expand the use of standardized developmental screening tools across health provider practices, early intervention, and early childhood education which promote early identification, prevention, and services for social and emotional health among maternal child populations.

c. Plan for the Coming Year

During the five year needs assessment process as part of the prioritization steps in determining the new ten state performance measures was taking a look at the old state performance measures and aligning them with the new MCH priorities. The Leadership team accepted responsibility for this task by reviewing the definition sheets for the current state performance measures, and assessing ODHs progress or outstanding issues related to each one. Based on that feedback, and review of the nine critical priorities a decision was made whether or not a past performance measure would be carried forward for consideration in the next 5 year grant period. Those that had been successfully completed and/or were incorporated into other work were dropped, and additional measures were selected.

The FFY 2006 - 2010 SPM 03 was not selected as one of the new state performance measures. The majority of the activities associated with this measure have been completed and on-going monitoring will occur through the LAUNCH program and in ODH's work with the ODMH in the creation of strategic plan for a Public Health Approach to Children's Mental Health.

State Performance Measure 4: *Degree to which Division of Family and Community Health Services programs can incorporate and evaluate culturally appropriate activities and interventions*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		2	3	4	4
Annual Indicator		2	3	4	5
Numerator		2	3	4	5
Denominator	5	5	5	5	5
Data Source				Program Benc	Program Benc
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5	5	5	5	

Notes - 2008
The FFY 08 target for this process measure was to complete 4 of 5 steps: 1) Programs describe the racial/ethnic/cultural makeup of MCH populations served; 2) Programs describe culturally appropriate activities they are undertaking to address racial/ ethnic/cultural disparities; 3) Assess existing tools used for cultural competence; and 4) assess existing and needed partnerships. Ohio has completed the first three steps completely and step four partially.

Notes - 2007
The FFY 07 target for this process measure was to complete 3 of 5 steps: !) Programs describe the racial/ethnic/cultural makeup of MCH populations served and underserved; 2) Programs describe culturally appropriate activities they are undertaking to address racial/ ethnic/cultural disparities; and 3) Assess existing tools used for cultural competence. Ohio has completed all three steps, and has met the FFY 07 target.

a. Last Year's Accomplishments
Develop and enhance a division-wide profile of populations served by DFCHS programs
1. Include eligibility requirements that specify populations to be served.
2. Identify how racial and ethnic data are collected and reported [in DFCHS] Completed.
   a. DFCHS began a process to assess the races, ethnicities and language of people being served in its MCH programs, through a face to face survey process.
   b. Findings of the survey process have been drafted, recommendations were identified and next steps will occur during FFY11.

This infrastructure-level strategy will be accomplished through the following activities:

1. Update DFCHS profile of populations served by program (information also needed annually for MCH BG Forms 7 and 8).
   a. This activity is on-going and has been partially collected, the activity will continue and is expected to be final within FFY11.
2. Share profile information, especially in regard to collection and reporting of racial/ethnic data, with all DFCHS Bureaus.
   a. Upon completion of updating the profile of populations the reports will be shared across all DFCHS Bureaus.
3. Based on identified gaps in population profile data collected by DFCHS programs; e.g., racial/ethnic data; collaborate with the ODH Public Health Data/Research Policy Advisory Committee (OPHDRPAC) to train DFCHS staff on ODH data standards for the purpose of improving collection of data on race and ethnicity across programs.
   a. This collaboration is currently in process. Once the ODH Race and Ethnicity Data Use Guidelines are finalized, DFCHS staff will be trained on the guidelines.
4. Collaborate with OPHDRPAC to develop ODH standards for tabulating racial/ethnic data for the purpose of improving the reporting of data in a consistent manner across programs.
   a. In process, related to #3 above.
5. Collaborate with the ODH Public Health Data/Research Policy Advisory Committee to train DFCHS staff on standards for tabulating racial/ethnic data for the purpose of improving the reporting of data in a consistent manner across programs.
   a. This process will be initiated upon completion of #3 above.
6. Complete the development and field testing of guidance on collection of race/ethnicity data for local grantees, especially as related to compliance with CLAS standards.
   a. This process will be initiated upon completion of #3 above.

Incorporate selected culturally appropriate activities and interventions into State DFCHS programs
This infrastructure-level strategy will be accomplished through the following activities:
1. Continue to participate in the National Center for Cultural Competence's new initiative for leadership in cultural and linguistic competence. The learning collaborative was extended to a second year.
   a. ODH participation will continue.
2. Continue to support ODH efforts, through the ODH Health Disparities Council and the Office of Healthy Ohio, Health Equity Coordinator, to incorporate core requirements for cultural competency into ODH contract and RFP language. Activities include the development of a common definition of cultural competence that can be used across ODH programs.
   a. Completed - RFP language has been changed to incorporate core requirement of cultural competency.
3. Based on technical assistance requested from the National Center for Cultural Competence, train ODH staff and local grantees on requirements/recommendations for cultural/linguistic competence, as outlined in Title VI of the Civil Rights act and as recommended in CLAS standards. Training would emphasize the planning for and the process of becoming culturally/linguistically competent what tools to use to monitor progress.
   a. NCCC conducted a two-day consultation and training with ODH staff on cultural and linguistic competency and introduced a plan for infusing cultural and linguistic competence into all block grant activities.
4. Collaborate with ODH efforts to develop standards and performance measures for moving toward cultural and linguistic competence for ODH staff and for grantees/vendors who must comply with RFP/contract language.
   a. On-going: currently working with the ODH Health Equities Coordinator and the ODH Health Disparities Council.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Develop and enhance a division-wide profile of populations served by DFCHS programs.				X
2. Incorporate selected culturally appropriate activities and interventions into State DFCHS programs.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Development of an Ohio Title V program plan that maps out a process to assist state-level Title V program staff and local grantees in moving along the continuum to cultural and linguistic competency. The plan should include guidance and/or tools for incorporating cultural/linguistic competence into each of the MCH BG national and state performance measures, as appropriate and for monitoring progress at both the state and grantee levels.

a. On-going: Some important steps towards reaching this goal have been accomplished with the technical assistance training conducted by the National Center for Cultural Competency (see FFY09 B.3# comments).

b. RFP language has been changed to incorporate cultural competency as a core requirement.

c. Cultural competency definitions, etc. have been proposed by the ODH Cultural and Linguistic Competency work group.

d. On-going: Work is in progress with the collaboration of a statewide cultural competency group called Multi-ethnic Advocates for Cultural Competency (MACC) lead by Executive Director Charleta Tavares, former Ohio House of Representatives member.

2. Develop a train-the-trainer workshop that Ohio can use to implement the plan described in "A" and that will market the importance and the "how-to's" of cultural/linguistic competency to our state/local partners.

a. The train-the-trainer workshop has not been completed at this time. Will plan and propose a TA request.

c. Plan for the Coming Year

1. Develop and enhance a division-wide profile of populations served by DFCHS programs.

a. Finalize a DFCHS profile of populations served by program (information also needed annually for MCH BG Forms 7 and 8), and distribute across DFCHS bureaus.

b. Distribute and implement findings and recommendations from the DFCHS survey process: Assessment of the DFCHS Programs for collection, storage and reporting of racial, ethnic, and primary language data.

2. Collaborate with the ODH Public Health Data/Research Policy Advisory Committee to develop ODH standards for tabulating racial/ethnic data for the purpose of improving the reporting of data in a consistent manner across programs.

a. When finalized, the ODH: Proposed Race and Ethnicity Guidelines report will be shared as an official DFCHS guide and the recommendations implemented.

b. Train DFCHS staff on ODH data standards for the purpose of improving collection of data on race and ethnicity across programs.

3. Development of an Ohio Title V program plan that maps out a process to assist state-level

Title V program staff and local grantees in moving along the continuum to cultural and linguistic competency. The plan should include guidance and/or tools for incorporating cultural/linguistic competence into each of the MCH BG national and state performance measures, as appropriate and for monitoring progress at both the state and grantee levels.
a. Develop an implementation proposal for the cultural competency definitions/language drafted by the ODH Cultural and Linguistic Competency work group in cooperation with the Office of Healthy Ohio, Health Equity Coordinator.
b. Outline initiatives/activities/proposal associated with MCH programs and the collaboration with the statewide cultural competency group called Multi-ethnic Advocates for Cultural Competency (MACC) lead by Executive Director Charleta Tavares, former Ohio House of Representatives member.
c. Develop a train-the-trainer workshop that Ohio can use to implement the plan described in " 3 a above" and that will market the importance and the "how-to's" of cultural/linguistic competency to our state/local partners.
d. Draft a technical assistance request for the train-the-trainer workshop.
e. Seek input from the Ohio Commission on Minority Health, as appropriate.

State Performance Measure 5: *Percent of 3rd graders who are overweight*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		36.5	36	35.5	34
Annual Indicator	35.6	35.6	34.3	35.9	35.9
Numerator	45342	45342	43212	45596	45596
Denominator	127364	127364	125956	126855	126855
Data Source				Ohio BMI Survey	Ohio BMI Survey
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	34	34	34	34	

Notes - 2007
Source: Data is from Oral Health / BMI Survey of 3rd graders conducted in the 2006 - 2007 school year from a sentinel sample of 25 schools. Numerator: The actual number of children who met the definition of risk for or at overweight =397(population estimate = 43,212). Denominator: The actual number of children who were surveyed = 1,198 (population estimate = . 125,956).

a. Last Year's Accomplishments
Goal: To decrease the rate of obesity in the school aged population

Conduct data surveillance and monitoring activities.
1. Activities for the year included collection of data from WIC, CFHS and Rural Health using Obesity Inventory Tool. The information is used to develop an inventory of statewide resources/programs addressing the treatment of childhood obesity. WIC clinics are the major participants in the data collection efforts. Other MCH funded agencies include some CFHS clinics and local health departments. Data report from 2009 indicates that 69 counties have provided information on providers who treat childhood obesity issues. The data collected from the Obesity Inventory Tool was shared with the Office of Healthy Ohio for inclusion into their county profiles
2. Sentinel data collection continued in the 2008/2009 school year. As well as planning efforts for the county level surveillance project for Third grade students during the 2009/2010 school year. Report tracking BMI sentinel data is included.

Increase health care providers awareness and involvement in prevention and treatment initiatives
1. The second phase of Ounce of Prevention has been developed to reach the 6-12 year olds. Promotion of this program was done via CFHS and the Obesity Prevention Program in Healthy Ohio.
2. Ounce of Prevention was presented to the Ohio School Based Health Center Association to promote use of the program within school with clinics.

Explore new opportunities for collaboration.
1. Continue collaboration with the ODH office of Healthy Ohio obesity coordinator to support efforts of the Virtual Obesity Team. Efforts are underway to empower local health departments to assume the responsibility of collecting BMI data within schools located in their health jurisdiction by providing training and equipment to selected local health departments.
2. Work with WIC in conducting the 3rd grade BMI State and County School Sample to assist with collection of data.

Investigate evidence based interventions for the school aged population related to nutrition and physical activity.
1. ODH continues to work with ODE and the Coordinated School Health Team to promote the CATCH trainings and other evidence based curricula that can be offered to school staff. Staff partnered with HO to apply for and receive a grant from General Mills Foundation which enabled ODH to purchase additional CATCH kits.
2. In collaboration with Cincinnati Children's Hospital, ODE, ODJFS, ACS and Healthy Ohio a pilot was conducted of Buckeye Best for Child Care recognition program funded by Robert Wood Johnson. The study was conducted to determine if an incentive program helped to increase PA and Nutrition to 150 sites in Montgomery County. In addition to surveys and awards for exemplary programs two technical assistance trainings were held. Preliminary Results have been collected but are not available for distribution as of yet. Results will be analyzed and shared in 2010. Sample of the award is attached.

Participate in the development of a statewide plan for addressing childhood obesity
1. Continue to participate on the Office of Healthy Ohio's Advisory Council and in promoting the state obesity plan.
2. Work with state department of education to support improvement in nutrition standards in schools and to increase physical activity during the school day.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conduct data surveillance and monitoring activities.				X
2. Increase health care providers awareness and involvement in prevention and treatment initiatives.				X
3. Explore new opportunities for collaboration.				X
4. Investigate evidence based interventions for the school aged population related to nutrition and physical activity.				X
5. Participate in the development of a statewide plan for addressing childhood obesity.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Conduct data surveillance and monitoring activities
1. Continue to collect heights/weights of Sentinel School Sample (3rd grade) as well as county level data collection
2. Continue to develop/distribute report on BMI tracking multiple years of sentinel survey data

Increase health care providers' awareness and involvement in prevention and treatment initiatives
1. Expand training on BMI guidelines to local health departments throughout Ohio
2. Explore/share with medical providers available educational information on "Expert Committee

Recommendations Regarding the Prevention, Assessment,
and Treatment of Child and Adolescent Overweight and Obesity"
3. Expand Ounce of Prevention program to include health guidance for children through age 13 yrs

Continue current collaborations and facilitate the development of new potential internal and external partners
1. Promote PA and nutrition programs in schools through Action for Healthy Kids.
2. Coordinate CFHS grantees focusing on childhood obesity w/CVH grantees in ODH Office of Healthy Ohio to encourage collaboration/share resources
3. Work w/local health department and school nurses as BMI screeners in BMI school surveillance projects for 3rd & 7th grade

Investigate evidence based interventions for the school aged population
1. Work w/ODE to identify best practices related to nutrition and PE/PA and disseminate information on best practice models to school districts throughout Ohio
2. Continue training CATCH curriculum to schools throughout Ohio

c. Plan for the Coming Year
Conduct data surveillance and monitoring activities.
1. Review data from WIC, CFHS and Rural Health using Obesity Inventory Tool.
2. Conduct 7th grade BMI surveillance
3. Collaborate with Healthy Ohio on the childhood obesity projects
4. Analysis and reporting of the 2009-10 3rd grade data

Increase health care providers awareness and involvement in prevention and treatment initiatives
1. Continue to promote Ounce of Prevention program to health care providers.
2. Participate on the Ohio AAP Ounce of Prevention advisory committee

Explore new opportunities for collaboration.
1. Continue collaboration with the ODH office of Healthy Ohio obesity coordinator to support efforts of the Virtual Obesity Team.
2. Collaborate with Action for Healthy Kids supporting the work of improved nutrition and increased in PA.
3. Collaborate with Ohio After school network to provide training and develop standards that promote increased PA in afterschool programs across the state.
4. Collaborate with the newly formed Buckeye Healthy School Alliance (formerly SPCHEO)

Investigate evidence based interventions for the school aged population related to nutrition and physical activity.
1. Work with the ODE Physical Education Department and the Coordinated School Health Team to promote evidence based PA programs in schools.
2. Through ARRA program continue to promote the CATCH trainings

Participate in the development of a statewide plan for addressing childhood obesity

1. Assist the Office of Healthy Ohio in promoting the state obesity plan.
2. Offer participation in the MCH Block Grant Meetings to the Obesity Prevention Coordinator.

State Performance Measure 6: *Assess the contribution of safety net providers in meeting the need for primary care, mental health, and dental services*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		1	1	2	2
Annual Indicator		1	1	1	1
Numerator		1	1	1	1
Denominator	3	3	3	3	3
Data Source				Program Benc	Program Benc
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3	3	3	3	

Notes - 2009
The 2009 data is currently not available, 2008 data was used as an estimate. This indicator has been discontinued and the final data will be reported in the next FFY.

Notes - 2008
This is a process measure that will be measured by the extent to which three benchmarks can be reached. The target for Calendar Year 2007 was that two benchmarks: 1) "Method is developed to measure access to care "and 2) "Uniform data system is developed to measure services provided by safety net providers" would be reached. The first benchmark has been reached, but not the second. Ohio did not meet its target.

Notes - 2007
This is a process measure that will be measured by the extent to which three benchmarks can be reached. The target for Calendar Year 2007 was that one benchmark: "Method is developed to measure access to care" would be reached. Ohio did meet its objective.

a. Last Year's Accomplishments
This is a process measure that will be measured by the extent to which three benchmarks can be reached and that is designed to assess the contribution of safety net providers in meeting the need for primary care, mental health, and dental services.

A. Apply the Health Professional Shortage Area (HPSA) methodology that can be used across the DFCHS to recruit and retain primary care health care providers who serve the medically underserved in HPSAs. This infrastructure-level strategy included the following activities: 1) report the number of current HPSAs due for renewal; 2) report the number of current HPSAs that will be renewed; 3) report on the number of new HPSAs requested by outside entities; 4) report on the number of potential new HPSAs identified by internal staff; 5) identify other programs in DFCHS that can apply HPSA methodology to identify unmet needs in primary care. Activities 1, 2, 3, and 4 have been completed. Activity 5 has been discussed at workgroup meetings but needs further follow-up.

B. Measure gaps in access to primary care and the contribution of safety net providers. This infrastructure-level strategy included the following activities: 1) report the number of primary care vacancies in HPSAs that have been vacant for at least 6 months; 2) report the number of primary

care providers placed in HPSAs through PCO recruitment/retention programs; 3) develop and implement a system to monitor the retention rate of primary care providers placed for 2 years past their final obligation date.
Activities 1 and 2 and 3 have been completed.

C. Assess access to care in HPSAs. This infrastructure-level strategy included the following activities: 1) assess the feasibility of collecting utilization data using existing surveys or new surveys; 2) conduct analysis of OHA data for ambulatory sensitive conditions such as pediatric asthma and type 2 diabetes.
These activities have been discussed at workgroup meetings but need further follow-up.

D. Assess the availability and accessibility of mental health data. This infrastructure-level strategy was not completed as it was not considered the highest priority strategy.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Recruit/retain primary care providers serving the medically underserved in HPSAs by reporting number, those due for renewal; those renewed; those requested by outside entities; those identified by internal staff.				X
2. Measure gaps in access to primary care (PC) and contribution of safety net providers by reporting number of PC vacancies in HPSAs; PC providers placed in HPSAs via PCO recruitment/retention programs; and monitoring retention rate of PC providers.				X
3. Assess access to care in HPSAs by assessing the feasibility of collecting utilization data using existing surveys or new surveys; conducting analysis of OHA data for ambulatory sensitive conditions such as pediatric asthma and Type 2 diabetes.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The work group met in 2009 to discuss plans for the coming year (FY '10) and any proposed changes to the strategies currently in place for this measure. Strategies for FY'10 are similar to the FY'09 reported strategies (see below):

1. Apply the Health Professional Shortage Area (HPSA) methodology to recruit and retain primary care, mental health, and dental health providers who serve the medically underserved in these federally designated HPSAs.
2. Measure gaps in access to primary care, mental health, and oral health services and the contribution of safety net providers in addressing these gaps.
3. Assess access to primary care, mental health, and oral health services in HPSAs.

A 4th strategy identified in FY'09 is not being pursued in FY'10 as it was not considered the highest priority for the workgroup. That strategy was to assess the availability and accessibility of

mental health data. Proposed activities in the 2nd strategy (measure gaps…) and the 3rd strategy (assess access…) include identifying providers statewide that provide direct care services to the MCH population and develop maps (utilizing geo-coding) depicting the location of these providers, measuring pediatric access to a dental provider in the past 12 months for preventive care, and access to a health care home. The work group has not yet convened in calendar year 2010 to discuss the feasibility of completing these proposed new activities.

c. Plan for the Coming Year

During the five year needs assessment process as part of the prioritization steps in determining the new ten state performance measures was taking a look at the old state performance measures and aligning them with the new MCH priorities. The Leadership team accepted responsibility for this task by reviewing the definition sheets for the current state performance measures, and assessing ODHs progress or outstanding issues related to each one. Based on that feedback, and review of the nine critical priorities a decision was made whether or not a past performance measure would be carried forward for consideration in the next 5 year grant period. Those that had been successfully completed and/or were incorporated into other work were dropped, and additional measures were selected.

This measure is housed in the Rural Health Infrastructure and Community Development section of DFCHS and will continue as on-going work.

State Performance Measure 7: *Percentage of 3rd grade children with untreated caries*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	20	29	20	20	20
Annual Indicator	25.4	23.9	23.7	23.0	23.0
Numerator	3565	225	30159	29814	29814
Denominator	14029	941	127147	129671	129671
Data Source				2007/2008 Sentinel School Survey	2007/2008 Sentinel School survey
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	19	18	18	18	

Notes - 2009

The 2009 data is currently not available, the 2008 data is being used as an estimate for 2009, we anticipate being able to finalize the 2009 data in the next FFY11 BG.

Notes - 2008

Data Source: From the 2007/2008 Sentinel School Survey consisting of 30 schools from which a population based estimate can be determined..
Numerator: Actual number of children with untreated caries in the sample = 283 (population estimate = 29,814). Denominator: Actual number of children screened = 1168 (population estimate = 129,671).

This is sentinel data and may be subject to small fluctuations that are not representative of the population of 3rd graders.

Notes - 2007
Data Source: From the 2006/2007 Sentinel School Survey consisting of 25 schools from which a population based estimate can be determined..
Numerator: Actual number of children with untreated caries in the sample = 270 (population estimate = 30159). Denominator: Actual number of children screened = 1147 (population estimate = 127146).

a. Last Year's Accomplishments
Encourage and enable Ohio communities to prevent dental caries through community-based fluoride promotion.
BOHS updated current and specific data on water fluoridation status for community water systems in Ohio that were surveyed by the Ohio EPA. The updated information was posted on the ODH Website.

Technical assistance (TA) was provided to local residents in Yellow Springs and Athens, Ohio where opponents of fluoridation were active. TA was also provided to Ohio EPA environmental scientists who inspect water systems. Of the 213 Ohio fluoridated systems, a sample of 84 were selected to be monitored. BOHS staff surveyed monthly operating reports and reported the data to the Centers for Disease and Control. Seventy four (74) Ohio water plants received Water Fluoridation Quality Awards from the Centers for Disease Control.

Nine community water systems received funding from the BOHS Fluoridation Reimbursement Program in FFY 2009. A total of $16,856.26 was provided to water systems to improve/implement fluoridation in FFY 09. Approximately 51,576 individuals are served by these nine water systems.

In addition, lectures were provided to dental and dental hygiene students at the Ohio State University and Columbus State Community College. Nurses at Nationwide Children's Hospital, Columbus, were provided data on fluoride use for infants.

Strengthen and support the dental care safety net.

BOHS funded 21 subgrants for expansion and/or operations (uncompensated care) to support safety net dental clinics; the funded safety nets reported providing dental care to 49,332 unduplicated patients.

BOHS collaborated with private foundation partners to implement the technical assistance program of the Oral Health Capacity Building project utilizing a professional team (IHS dentist and expert in safety net fiscal operations) to evaluate and provide technical assistance to 7 targeted agencies interested in improving operations and increasing efficiencies in their safety net dental clinics.

The Ohio Dental Safety Net Information Center, a comprehensive online portal to tools and information necessary to start and maintain the operations safety net dental clinics in Ohio, was developed via a contract between the Ohio Department of Health and the National MCH Oral Health Resource Center at Georgetown University.

Included in this resource are several online trainings that provide free dental continuing education credit that is relevant to dentists working in dental safety net and school-based dental sealant programs.

The Ohio Dentist Loan Repayment Program provided funds for 7 dentists who continued their obligations for loan repayment and two new dentists who received loan repayment beginning in early 2009. Participating dentists reported providing care for 13,058 unduplicated patients who were uninsured or on Medicaid.

Ten renewal and two new applications for federal Dental Health Professional Shortage Area (HPSA) designations were submitted to HRSA's Bureau of Health Professions in 2009. There are currently 57 dental HPSA designations in Ohio.

Assist communities in taking action to improve oral health.

County-level oral health data were updated in the Ohio Oral Health Surveillance System, which enables communities to describe local oral health status and access to dental care in their communities.

Planning occurred for the next statewide oral health survey of Ohio schoolchildren to be conducted in all counties during the 2009-10 school year.

Training on Help Me Smile, on oral health curriculum for use by home visitors working with families of high-risk infants and toddlers, was provided to staff from 14 agencies (Help Me Grow, WIC, Child and Family Health Services, Early Head Start/Head Start and BCMH). Training on Smiles for Ohio-Fluoride Varnish was provided to staff from 9 agencies (pediatric practices, FQHC's, and Local Health Departments).

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Enable Ohio communities to prevent dental caries via community-based fluoride promotion by posting updated information to the ODH website; providing TA to local communities; providing funding to water systems.				X
2. Provide funding to 21 subgrantees for expansion and/or operations (uncompensated care) to support safety net dental clinics.				X
3. Collaborate with private foundation partners to implement the technical assistance program of the Oral Health Capacity Building project.				X
4. Develop the Ohio Dental Safety Net Information Center, a comprehensive online portal to tools and information necessary to start and maintain the operations safety net dental clinics in Ohio.				X
5. Provide funding for the Ohio Dentist Loan Repayment Program; and providing for new and renewal applications for federal Dental Health Professional Shortage Area (HPSA) designations.				X
6. Update the Ohio Oral Health Surveillance System, which enables communities to describe local oral health status and access to dental care in their communities.				X
7. Plan for the next statewide oral health survey of Ohio schoolchildren to be conducted in all counties during the 2009-10 school year.				X
8. Provide training on Help Me Smile, on oral health curriculum for use by home visitors working with families of high-risk infants and toddlers and Smiles for Ohio-Fluoride Varnish to internal and external stakeholders.				X
9.				
10.				

b. Current Activities

A. Fund (through subgrants) local agencies to operate efficient, high quality school-based dental sealant programs. The Oral Health Program is in the process of developing an expansion plan for the school-based sealant program (S-BSP) and will implement the plan in the 2010-2011 school year. A Workforce Grant application was submitted to HRSA in April, requesting additional funds to help support the expansion of dental sealant plans into additional qualifying schools and providing preventive dental sealants.

B. In CY 2011, 25,000 students in higher-risk schools will receive dental sealants through ODH-funded School-Based Sealant Programs (S-BSPs). (Baseline: 19,386 in CY 2008). Additionally, the infection control portion of the Ohio School-based Dental Sealant Program Manual is being updated following a review of the Organization for Safety, Asepsis and Prevention's (OSAP) recently released infection control checklist.

C. Implement the BOHS performance improvement plan for OHD-funded school-based sealant programs. The program will include development and communication of a manual for Ohio sealant programs, analysis of quarterly report data and other documentation, and site visits.

D. An on-line a distance learning curriculum for school-based sealant program staff was completed and posted online.

c. Plan for the Coming Year

A. Encourage and enable Ohio communities to prevent dental caries through community-based fluoride promotion.
This population-level strategy will be accomplished through the following activities:
1. Maintain fluoridation and related information on the BCHS Website;
2. Maximize the impact of Ohio's fluoridation statute through fluoridation promotion and education efforts;
3. Provide limited reimbursement for start-up and maintenance costs of water fluoridation; and
4. Collaborate with Ohio EPA to evaluate fluoridation quality and monitor the state fluoridation census.

B. Strengthen and support the dental care safety net.
This infrastructure-level strategy will be accomplished through the following activities:
1. Fund subgrants for support to safety net dental clinics;
2. Monitor quality and improvement of the Safety Net dental care subgrants utilizing the Oral Health Program's quality assessment and improvement methodology.
3. Provide technical assistance to agencies interested in operating safety net dental clinics;
4. Continue to collaborate with the National Maternal and Child Oral Health Resource Center on development of distance learning modules for the Ohio Safety Net Dental Clinic Website;
5. Collaborate with Safety Net Solutions, the Association of State and Territorial Dental Directors, the Indian Health Service, the National Maternal and Child Oral Health Resource Center to maintain and improve the safety net dental clinic manual (www.dentalclinicmanual.com);
6. Administer the Ohio Dentist Loan Repayment Program; and
7. Prepare and submit renewal and new applications for federal Dental Health Professional Shortage Area (HPSA) designations in Ohio.

C. Make data and other information available to help communities and policy-makers.
This infrastructure-level strategy will be accomplished through the following activities:
1. Maintain and update a county-level, internet-based oral health surveillance system to describe oral health status, demographics and access to dental care factors;
2. Write and disseminate reports (or manuscripts for publication in professional journals) on oral health data;
3. Conduct the 2010-11 oral health survey of third grade students in 30 sentinel schools and

conduct analysis of data;
4. Maintain the Oral Health Program's Website as a rich information source on oral health, oral health policy issues, and the Oral Health Section's programs/funding opportunities that are coordinated with the Ohio Safety Net Dental Clinic Website; and
5. Provide information, consultation and technical assistance to customers, as requested (e.g., local health departments, school staff, consumers).
6. Mobilize members of the Children's Oral Health Action Team (COHAT) and its member networks to secure authority to implement its children's oral health advocacy agenda.

State Performance Measure 8: *Implement Ohio Connections for Children with Special Needs (OCCSN) Birth Defects Registry System*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		1	3	4	4
Annual Indicator		1	3	4	4
Numerator		1	3	4	4
Denominator	4	4	4	4	4
Data Source				Program Benc	Program Benc
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	4	4	4	4	

Notes - 2009
The 2009 data is currently not available, 2008 data is being used as an estimate for 2009, we anticipate finalizing the 2009 data in the next FFY BG application.

Notes - 2008
This is a process measure that will be measured by the extent to which four benchmarks can be reached. The target for FFY 2008 was that four benchmarks would be reached: 1) implement a birth defects data collection and referral to services pilot project: 2) build a birth defects data system (infrastructure) that meets program needs for surveillance, case reporting, data sharing/integration; 3) implement a state plan of action for birth defects prevention activities; and 4) expand to a statewide birth defects system. Ohio has met its target.

Notes - 2007
This is a process measure that will be measured by the extent to which four benchmarks can be reached. The target for FFY Year 2007 was that three benchmarks would be reached: 1) implement a birth defects data collection and referral to services pilot project; 2) build a birth defects data system (infrastructure) that meets program needs for surveillance, case reporting, data sharing/integration; and 3) implement a state plan of action for birth defects prevention activities. Ohio has met its goal for 2007.

a. Last Year's Accomplishments
Strategies to meet Benchmark #1 -- Implement a birth defects data collection and referral to services project.
1. Continue collecting data from hospitals monthly.
2. Implement OCCSN referral to Help Me Grow protocol statewide (88 counties).
3. Provide training on working with children with birth defects as an ongoing component of the Help Me Grow Leadership Institute.
Report of Accomplishment: Complete and Ongoing

All hospitals in the state report birth defects data to ODH monthly. Hospital data submissions are monitored by OCCSN staff to ensure timeliness and completeness. Genetic counselors provided trainings on working with children with birth defects as part of the ongoing Help Me Grow Leadership Institute (Part C early intervention) and were well received. The trainings were discontinued during FFY09 due to planning efforts to move Part C early intervention to the state Dept. of Education. All trainings were put on hold, but plan to resume in the future utilizing a webinar format, rather than on-site face to face. After a comprehensive evaluation of the referral protocol, five counties continue to test and refine the referral to services protocol. Plans to expand to additional counties are underway for FFY10.

Strategies to meet Benchmark #2 -- Build a birth defects data system (infrastructure) that meets program needs for surveillance, case reporting, data sharing/integration.
1. Improve the quality of the data reported through monthly monitoring of missing data; building routines to alleviate problems; improve matching records with Vital Statistics; and reducing duplicate records.
2. Conduct open, monthly technical assistance calls with data reporters to discuss common problems with reporting, troubleshoot issues, and obtain feedback.
Report of Accomplishment: Complete and Ongoing
Concentrated efforts of an epidemiologist and IT staff have improved OCCSN data quality and routines programmed within the system will improve future data reported. Technical assistance calls are held when requested, or when the need arises. An evaluation survey showed that hospitals do not want monthly calls, only when there is new information to present. A procedure manual was developed to document routines and procedures for OCCSN.

Strategies to meet Benchmark #3 -- Implement a state plan of action for birth defects prevention activities.
1. Promote Birth Defects Prevention Awareness Month, January 2009.
2. Explore data sources to determine if there are special populations in Ohio at risk for birth defects for targeted birth defects prevention education.
3. Implement prevention project as determined by Ohio Partners for Birth Defects Prevention (OPBDP).
Report of Accomplishments: Complete and Ongoing

ODH coordinates statewide efforts to promote Birth Defects Prevention Awareness Month and conducts an online survey to collect information about activities and events held during the awareness month. Maternal obesity data was studied, and a project is planned for FFY10. The OCCSN coordinator participates on a national committee to develop the prevention month theme and toolkit. The OCCSN website was developed and efforts continue to post resources and information for providers and the public. Ohio data on maternal obesity was analyzed and a collaborative project with other MCH programs and WIC is planned for 2010.

The OPBDP collaborated with the Columbus City Health Department to develop a women's wellness prescription pad for physician offices to use with women during clinic encounters. Plans are under development to take this project statewide in FFY10 through coordinated activities between MCH programs such as genetic centers and family planning clinics.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implement a birth defects data collection and referral to services project.				X
2. Build a birth defects data system infrastructure that meets program needs for surveillance, case reporting and data sharing.				X

3. Implement a state plan of action for birth defects prevention activities.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Implement a birth defects data collection and referral to services project
• Hospitals will report children from birth to 5 yrs of age with birth defects to ODH monthly
• Expand participation in the referral to services component of OCCSN
• Genetic Centers will provide education on birth defects as part of EI training
• Work with EI and BCMH to ensure children with birth defects are referred to programs

Build a birth defects data system (infrastructure) that meets needs for surveillance, case reporting, data sharing/integration
• Enhance data quality through follow-up with hospitals; improved matching with Vital Statistics; and merging duplicates
• Utilize Genetic Center Data System and staff to validate select diagnoses
• Develop report for wide distribution with prevalence data for select birth defects
• Develop operations manual

Implement plan of action for birth defects prevention activities
• Develop/implement preconception activity
• Participate in Infant Mortality Task Force
• Participate in March of Dimes, Improved Birth Outcomes Conference, Nov. 2009
• Ohio Partners for Birth Defects Prevention will meet and promote efforts to improve education of public and health professionals about preventable birth defects
• Participate on Fetal Alcohol Spectrum Disorders State Steering Committee
• Promote Birth Defects Prevention Awareness Month (January)
• Review results from Ohio's BRFSS for relevance to preconception, genetics, chronic disease prevention and birth defects issues

c. Plan for the Coming Year

Several of the needs identified as priority areas for the FFY06 needs assessment continue to be priorities and will carry forward as FFY11 performance measures. Birth outcomes, including infant mortality and LBW; coordination of services for CSHCN; gaps in services for CSHCN; and access to oral health services for children and adolescents remain as important focus areas for the Title V program.

Services for CSHCN that are coordinated and comprehensive (no gaps) remain a challenge in a climate of decreased funding, inadequate insurance coverage, provider shortages and access to care issues. Continuing access problems for children in need of oral health care services keep this issue as a high priority in the Title V program. The current state performance measure to implement the Ohio Connections for Children with Special Needs (OCCSN) birth defects information system is successfully under way and therefore ODH will not continue with the current SPM 08. The new state performance measure for the maintenance and enhancement of the Ohio Connections for Children with Special Needs (OCCSN) birth defects information system (BDIS) birth defects registry) to improve utilization of data of surveillance, referrals to services and

prevention activities will replace this performance measure.

State Performance Measure 9: *Increase the proportion of children who receive age-and risk-appropriate screenings for lead, vision, and hearing.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		1	2	2	3
Annual Indicator			25.0	50.0	50.0
Numerator			1	2	2
Denominator	9	9	4	4	4
Data Source				Program Benchmarks	Program Benchmarks
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3	4	4	4	

Notes - 2009
The 2009 data is currently not available, 2008 data has been used as an estimate for 2009. We anticipate being able to finalize the 2009 data in the next FFY BG application.

Notes - 2008
This is a process measure that will be measured by the extent to which four benchmarks can be reached. The target for FFY 2008 was that two benchmarks: 1) Define age of population to measure; and 2) Define what constitutes a "screening" for age group defined" would be met. The target was reached.

a. Last Year's Accomplishments
Identify available data sources and/or explore data collection methods to measure specific impact of activities on preschool screening rates for vision and hearing.

The workgroup has reached agreement on the definition of screening for lead, vision, and hearing and has defined the population on which the group will focus. Screenings meet the standard definitions of visual acuity, stereopsis, and other guidelines established for school-aged children and by AAP for vision; a pure tone hearing screen and optional OAEs/tymps when available for hearing; and a blood lead test for lead. The hearing and vision groups will focus on improving screening rates for the preschool population (specifically ages 3 through 5); the lead group will focus on screening 1 and 2 year olds. The workgroup established agreement upon those definitions as benchmarks for FFY07, and both are completed. The group continues to discuss ongoing data collection methods for assessing impact on preschool screening rates as a result of workgroup activities; Ohio has made changes to its vision and hearing screening survey and school nurse survey in an effort to establish a baseline for screening rates.

Utilize results and analysis of FFY08 provider survey in developing strategies to improve capacity to screen children in the well-child health care setting.

The workgroup focused on this activity in FFY09 and will continue to focus on this activity in FFY10. The workgroup has produced, distributed and analyzed a physician survey to determine the successes with and barriers to providing vision/hearing/lead screenings; in FFY10, the workgroup will focus on developing and implementing outreach strategies to improve the capacity to screen children in the well-child health care setting. In addition, the state continues to educate primary care providers on the importance of lead testing through PLANET. The state also

continues to work with partners to assure medical students are trained on the importance of vision and screening during residency.

Identify one specific activity for each screening area (lead, hearing, and vision).

For vision screenings, Ohio has successfully trained Healthy Child Care Ohio consultants to train local child care providers on conducting vision screenings for children in their care; they also provide vision screening equipment to child care providers. For hearing screenings, the same Healthy Child Care Ohio consultants have received pure tone audiometers to conduct hearing screenings in child care settings. For lead testing, the workgroup continues to collaborate with the Ohio Lead Advisory Council, specifically its targeted testing workgroup, to improve lead testing rates. In FFY07, the state initiated blood lead testing in WIC clinics, which has dramatically improved Ohio's ability to reach at-risk children. This collaboration has continued through FFY09.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Identify available data sources and/or explore data collection methods to measure specific impact of activities on preschool screening rates for vision and hearing.				X
2. Revise Ohio's vision and hearing screening survey and school nurse survey in an effort to establish a baseline for screening rates.				X
3. Work with partners to assure medical students are trained on the importance of vision and screening during residency.				X
4. Utilize results and analysis of FFY08 provider survey in developing strategies to improve capacity to screen children in the well-child health care setting.				X
5. Train Healthy Child Care Ohio consultants to train local child care providers on conducting vision and hearing screenings and provide equipment as needed.				X
6. Collaborate with the Ohio Lead Advisory Council to improve lead testing rates.				X
7.				
8.				
9.				
10.				

b. Current Activities

A. Identify data sources and/or data collection methods to measure impact of activities on preschool screening rates for hearing/vision. Ohio's Childhood Lead Poisoning Prevention Program has a statewide surveillance system and statutory requirements for labs to report lead screening data. There is no data collection tool to measure hearing/vision. The group will seek out methodology that accommodates tracking the number of preschool children screened. This strategy will complement existing measure of comparing kindergarten screening fail rates over time.

B. Utilize analysis of FFY08 provider survey in developing strategies to improve capacity to screen children in well-child health care setting. The workgroup successfully distributed a survey to primary care providers throughout Ohio and will use the data to provide solutions to training needs and, at a policy level, cost limitations. This follow-up will help advance the population-based service of improving screening rates of children before they enter school.

C. Identify one specific activity for each screening area (lead, hearing, vision). The workgroup formed three subcommittees focused on lead, hearing, and vision screenings. Lead will work on maintaining blood lead testing in WIC clinics. Hearing and vision will work through the Healthy Child Care Ohio program to train/provide screening equipment to child care providers (vision) and train Healthy Child Care Ohio nurses to conduct screenings while on-site (hearing).

c. Plan for the Coming Year

Several of the needs identified as priority areas for the FFY06 needs assessment continue to be priorities and will carry forward as FFY11 performance measures. Birth outcomes, including infant mortality and LBW; coordination of services for CSHCN; gaps in services for CSHCN; and access to oral health services for children and adolescents remain as important focus areas for the Title V program.

Continuing access problems for children in need of oral health care, hearing, vision and lead screening services keep this issue as a high priority in the Title V program. The current state performance measure to increase the proportion of children who receive age- and risk-appropriate screenings for lead, vision and hearing is successfully under way through out Ohio therefore ODH will not continue with the current SPM 09 as it is currently written. A new state performance measure that will focus on quality improvement efforts to increase the proportion of children who receive age and risk-appropriate screenings for lead, vision and hearing will replace this performance measure.

State Performance Measure 10: *Integrate ODH Maternal and Child Health Information Systems*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		1	2	3	4
Annual Indicator		1	1	2	2
Numerator		1	1	2	2
Denominator	6	6	6	6	6
Data Source				Program Benc	Program Benc
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5	6	6	6	

Notes - 2009

The 2009 data is currently not available, 2008 data has been used as an estimate for 2009. This SPM is being discontinued and we anticipate being able to finalize the 2009 data in the next FFY BG application.

Notes - 2008

This is a process measure that will be measured by the extent to which six benchmarks can be reached. The target for FFY 2008 was to meet three of the six benchmarks: 1) assess data information needs; 2) identify barriers to data integration and propose recommendations to overcome them; and 3) develop an implementation plan. Most of the planned activities were completed. Lack of access to needed data prevented us from addressing some of the areas.

Notes - 2007

This is a process measure that will be measured by the extent to which six benchmarks can be reached. The target for FFY 2007 was to assess data information needs. While some progress was made, Ohio did not meet this target in FFY 2007.

a. Last Year's Accomplishments

This is a process measure that will be measured by the extent to which six benchmarks can be reached. The target for last year was to meet three of the six benchmarks:

1. Assess data information needs
2. Identify barriers to data integration and propose recommendations to overcome them
3. Develop an implementation plan.

Most of the planned activities were completed.

Work continued on the priority areas of the Division of Family and Community Health Services (DFCHS). The following activities were completed:

1. Linkage of WIC, Vital Statistics, and Medicaid data

The plan for last year also called for addressing the two strategies listed below:

A. Assess the data integration needs of bureaus and identify opportunities for data integration.

Activities: Most of the assessment work related to this strategy was completed the previous year. Implementation work continued last year as noted above, based on short term priorities.

B. Develop a short term implementation plan. The plan includes the following activities:

1. Develop goals
2. Identify data bases
3. Develop Performance measures and data standards
4. Determine the quality of collected data and make recommendations to improve quality
5. Identify data access and sharing issues
6. Identify data users

Last year, we were able to access the needed database (WIC) and renewed the interagency agreement between the Ohio Dept. of Health (ODH) and the Medicaid program to access this data base to address DFCHS priority issues.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Link WIC, Vital Statistics, and Medicaid data as part of the assessment of data needs.				X
2. Assess the data integration needs of bureaus and identify opportunities for data integration.				X
3. Develop a short term implementation plan to include: goals; data bases; performance measures and data standards; quality of collected data and make recommendations to improve quality; data access and sharing issues; and data users.				X
4.				
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities

1. Continue data linkage activities as outlined in the short term implementation plan
2. Integrate child health data reporting into electronic lab reporting
3. Automate weekly release of birth data
4. Automate the linkage of MCH indicators at the community level

c. Plan for the Coming Year

During the five year needs assessment process as part of the prioritization steps in determining the new ten state performance measures was taking a look at the old state performance measures and aligning them with the new MCH priorities. The Leadership team accepted responsibility for this task by reviewing the definition sheets for the current state performance measures, and assessing ODHs progress or outstanding issues related to each one. Based on that feedback, and review of the nine critical priorities a decision was made whether or not a past performance measure would be carried forward for consideration in the next 5 year grant period. Those that had been successfully completed and/or were incorporated into other work were dropped, and additional measures were selected.

This measure has been incorporated into the work of the Maternal and Child Health Epidemiology Strategic Plan agenda, whose focus will be the systematic analysis and interpretation of population-based and program specific health and related ata in order to asses the distribution and determinants of health status and needs of the maternal and child population, for the purpose of implementing effective interventions and promoting policy development.

This plan will also focus on the following:

-Improve epidemiology and data capacity for MCH
-Strengthen synergy and integration of epidemiology/data with program/policy
-Coordinate the operational characteristics of the MCH epidemiology effort across units at ODH
-Develop and maintain an annual MCH analytic plan (project list) that integrates with Title V HP2020 department stretegic plan.

E. Health Status Indicators

Introduction

Introduction:

The Health Status Indicators (HSIs) as a group provide information regarding demographic characteristics of Ohio's Maternal Child Health population and the program participation of that population. The information is integrated into Ohio's MCH Needs Assessment and resulting prioritization, program planning and evaluation activities. The information allows us to identify and track changes in vital events such as births and deaths, by race, ethnicity and age; and in program use, by the same variables.

The process of accessing some of the data required for reporting on the HSIs results in the identification of new partners who can be recruited to serve as stakeholders for needs assessment activities and the identification of strategies to address disparities and gaps in outcomes and services to the MCH population.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	8.7	8.8	8.8	8.6	8.6
Numerator	12870	13222	13200	12791	12791
Denominator	148116	150510	150600	148408	148408
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The 2009 data is currently not available. 2008 data was used as an estimate for 2009.

Notes - 2008
2008 data are not available; 2007 data used as estimate for 2008

Notes - 2007
Data Source: Final 2007 Ohio Vital Statistics Resident Birth data, birthweight not missing.

Narrative:
"In Ohio in 2008, the LBW rate was 8.6 percent, higher than the national percentage of 8.2 in 2007. The Healthy People 2010 target of 5.0 percent has not been met. While Ohio's LBW rate increased from 7.5% in 1994 to 8.8% in 2006 (p=0.000), there has been no statistically significant change thereafter."

Recognizing the unacceptable rates and disparities in infant mortality in Ohio, in early 2009, Gov. Ted Strickland asked the Ohio Department of Health (ODH) to establish the Ohio Infant Mortality Task Force (IMTF) to (1) take a fresh look at the reasons behind Ohio's overall infant mortality rate and increasing disparities among different populations; and (2) develop recommendations and strategies to prevent infant mortality and disparities. A group of about 70 individuals made up the task force, including public and private health providers (some nationally recognized experts in the field), businesses, government agencies, associations, faith-based organizations, advocacy groups and consumers from across the state. Many community, county, and state-led programs and initiatives in Ohio have focused on the issue of infant mortality over the past several decades. The IMTF surveyed both ongoing efforts as well as research being done in Ohio and will work synergistically with these entities to maintain and/or improve the infant mortality efforts in Ohio.

In 2009 Governor Ted Strickland requested that the ODH establish a task force to study and report on infant mortality and disparities. A group of about 70 individuals made up the task force, co-chaired by Thomas G. Breitenbach, CEO of Premier Health Partners, Inc., and ODH Director Alvin D. Jackson, MD. In November 2009, the Ohio Infant Mortality Task Force (IMTF) issued its final report which provided extensive background information and included ten recommendations. The report is available at http://www.odh.ohio.gov/odhPrograms/cfhs/imtf/imtf.aspx.

The IMTF recommended the creation of an ongoing consortium to continue its work, and the ODH BCFHS has recently convened this consortium. The charge of the consortium is to implement and monitor the recommendations set forth by the task force and approved by the governor. The consortium members are working through the following committee structure to provide statewide leadership and coordination of efforts to prevent infant mortality and improve

the health of women of childbearing age and infants throughout Ohio: an Executive Committee and Workgroups including Coordinated health care throughout a woman's and child's life, Disparities and their underlying causes including racism, Data/Metrics/QI, Education/Outreach and Public Policy.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.8	6.9	7.0	6.8	6.8
Numerator	9727	10030	10100	9737	9737
Denominator	142735	145152	145307	143173	143173
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The 2009 data is currently not available. 2008 data was used as an estimate for 2009.

Notes - 2008
2008 data are not available; 2007 data are used as estimates for 2008.

Notes - 2007
Data Source: Final 2007 Ohio Vital Statistics Resident Birth data, birthweight not missing.

Narrative:
"In Ohio in 2008, the LBW rate among singleton births was 6.8 percent. It has not changed since 2005 when it was also 6.8 percent."

Recognizing the unacceptable rates and disparities in infant mortality in Ohio, in early 2009, Gov. Ted Strickland asked the Ohio Department of Health (ODH) to establish the Ohio Infant Mortality Task Force (IMTF) to (1) take a fresh look at the reasons behind Ohio's overall infant mortality rate and increasing disparities among different populations; and (2) develop recommendations and strategies to prevent infant mortality and disparities. A group of about 70 individuals made up the task force, including public and private health providers (some nationally recognized experts in the field), businesses, government agencies, associations, faith-based organizations, advocacy groups and consumers from across the state. Many community, county, and state-led programs and initiatives in Ohio have focused on the issue of infant mortality over the past several decades. The IMTF surveyed both ongoing efforts as well as research being done in Ohio and will work synergistically with these entities to maintain and/or improve the infant mortality efforts in Ohio.

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Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.6	1.6	1.7	1.6	1.6
Numerator	2385	2437	2550	2393	2393
Denominator	148116	150510	150600	148408	148408
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The 2009 data is currently not available. 2008 data was used as an estimate for 2009.

Notes - 2008
2008 data are not available; 2007 data used as estimate for 2008

Notes - 2007
Data Source: Final 2007 Ohio Vital Statistics Resident Birth data, birthweight not missing.

Narrative:
"In 2008, the Ohio VLBW rate was 1.6 percent. This was higher than the national rate of 1.5 in 2007 and higher than the HP 2010 target rate of 1.0 percent. A statistically significant increasing trend in VLBW percentage was observed in Ohio from 1994 through 2008 (p=0.000), however, between 2005 and 2008 there appears to have been no substantive change."

Recognizing the unacceptable rates and disparities in infant mortality in Ohio, in early 2009, Gov. Ted Strickland asked the Ohio Department of Health (ODH) to establish the Ohio Infant Mortality Task Force (IMTF) to (1) take a fresh look at the reasons behind Ohio's overall infant mortality rate and increasing disparities among different populations; and (2) develop recommendations and strategies to prevent infant mortality and disparities. A group of about 70 individuals made up the task force, including public and private health providers (some nationally recognized experts in the field), businesses, government agencies, associations, faith-based organizations, advocacy groups and consumers from across the state. Many community, county, and state-led programs and initiatives in Ohio have focused on the issue of infant mortality over the past several decades. The IMTF surveyed both ongoing efforts as well as research being done in Ohio and will work synergistically with these entities to maintain and/or improve the infant mortality efforts in Ohio.

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Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.2	1.2	1.3	1.2	1.2
Numerator	1737	1808	1918	1765	1765
Denominator	142735	145152	145307	143173	143173
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The 2009 data is currently not available. 2008 data was used as an estimate for 2009.

Notes - 2008
2008 data are not available; 2007 data used as estimate for 2008

Notes - 2007
Data Source: Final 2007 Ohio Vital Statistics Resident Birth data, birthweight not missing

Narrative:
"In Ohio in 2008, the VLBW rate among singleton births was 1.2 percent. It has not changed since 2005 when it was also 1.2 percent."

Recognizing the unacceptable rates and disparities in infant mortality in Ohio, in early 2009, Gov. Ted Strickland asked the Ohio Department of Health (ODH) to establish the Ohio Infant Mortality Task Force (IMTF) to (1) take a fresh look at the reasons behind Ohio's overall infant mortality rate and increasing disparities among different populations; and (2) develop recommendations and strategies to prevent infant mortality and disparities. A group of about 70 individuals made up the task force, including public and private health providers (some nationally recognized experts in the field), businesses, government agencies, associations, faith-based organizations, advocacy groups and consumers from across the state. Many community, county, and state-led programs

and initiatives in Ohio have focused on the issue of infant mortality over the past several decades. The IMTF surveyed both ongoing efforts as well as research being done in Ohio and will work synergistically with these entities to maintain and/or improve the infant mortality efforts in Ohio.

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Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.1	8.5	4.8	5.8	5.8
Numerator	206	193	102	122	122
Denominator	2264102	2269306	2104949	2087807	2087807
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The 2009 data is currently not available. 2008 data was used as an estimate for 2009.

Notes - 2008
2008 data are not available; 2007 data used as estimate for 2008

Notes - 2007
Data Source: Numerator - 2007 Vital Statistics death data.
Denominator - Bridged-race Vintage 2007 postcensal population estimates for 2007

Narrative:
"Prior to 2007, infants 0-364 days were included in Ohio's calculation of this HSI. The apparent dramatic decrease in unintentional injury death rate in children 14 years and younger after 2006 is due to elimination of infants 0-364 days in the calculation. In 2008, the unintentional injury

death rate in children 1 through 14 years was 5.8 per 100,000 (122 total deaths)."

Child fatality review (CFR) boards in Ohio's 88 counties review deaths from all causes for all children younger than 18. Boards share findings with local stakeholders and seek collaboration to develop initiatives to prevent injuries/deaths. ODH provides TA, training/tools to local CFR boards on ways to present/share/use information. Many local CFR boards actively supported efforts to strengthen enforcement of Ohio's Graduated Driver License law and passage of the Child Passenger Booster Seat law. ODH Title V program staff participate in the Ohio Injury Prevention Partnership, comprised of stakeholders with interests in injury prevention throughout Ohio. The group is facilitated through the Violence/Injury Prevention Program in the ODH Office of Healthy Ohio and organized a statewide symposium on the prevention of traumatic brain injury among Ohio's children.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	2.6	2.6	1.6	1.9	1.9
Numerator	59	55	33	40	40
Denominator	2264102	2127965	2104949	2087807	2087807
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The 2009 data is currently not available. 2008 data was used as an estimate for 2009.

Notes - 2008
2008 data are not available; 2007 data used as estimate for 2008

Notes - 2007
Data Source: Numerator - 2007 Vital Statistics death data.
Denominator - Bridged-race Vintage 2007 postcensal population estimates for 2007

Narrative:
"Prior to 2007, infants 0-364 days were included in Ohio's calculation of this HSI. Beginning in 2007, children 14 years and younger does NOT include infants 0-364 days. Based on final VS data for 2007, Ohio's unintentional injury death rate due to motor vehicle crashes in children 1 through 14 years old was 1.9 per 100,000."

Child fatality review (CFR) boards in Ohio's 88 counties review deaths from all causes for all children younger than 18. Boards share findings with local stakeholders and seek collaboration to develop initiatives to prevent injuries/deaths. ODH provides TA, training/tools to local CFR boards on ways to present/share/use information. Analysis of state CFR data increased understanding of the unique circumstances and risk factors related to vehicular deaths for 1-14

year olds, such as 36 percent of the deaths were to children who were pedestrians or on bicycles; and only 29 percent of the children killed were properly restrained. Many local CFR boards actively supported efforts to strengthen enforcement of Ohio's Graduated Driver License law, passage of the Child Passenger Booster Seat law and enhance programs to improve pedestrian safety and increase the use of bicycle helmets.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	19.0	18.7	19.8	16.2	16.2
Numerator	306	299	312	255	255
Denominator	1614620	1597458	1573926	1571723	1571723
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The 2009 data is currently not available. 2008 data was used as an estimate for 2009.

Notes - 2008
2008 data are not available. 2007 data are used as estimates for 2008

Notes - 2007
Data Source:
Numerator: Ohio Vital Statistics 2007 final death files
Demominator: U.S. Census/NCHS Bridged Race, Vintage 2007 Ohio population estimates for 2007.

Narrative:
"Based on final Vital Statistics data for 2008, Ohio's death rate for unintentional injuries for youth aged 15 through 24 years old due to motor vehicle crashes was 16.2 per 100,000 (255 deaths), which appears to be lower than the rates in 2005-7."

Child fatality review (CFR) boards in Ohio's 88 counties review deaths from all causes for all children younger than 18. Boards share findings with local stakeholders and seek collaboration to develop initiatives to prevent injuries/deaths. ODH provides TA, training/tools to local CFR boards on ways to present/share/use information. Because vehicular crashes is the leading cause of unintentional deaths to Ohio's youth, many CFR boards actively supported efforts to strengthen enforcement of Ohio's Graduated Driver License law.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	177.8	178.4	184.5	179.7	157.6
Numerator	4026	3787	3883	3783	3318
Denominator	2264102	2122965	2104949	2104949	2104949
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: Data was provided as a courtesy by the Ohio Hospital Association Clinical and financial Database.

Notes - 2008
Source: Data was provided as a courtesy by Ohio Hospital Association Statewide Clinical and Financial Database.

Notes - 2007
.Data source: Numerator - Ohio Hospital Association (OHA) Statewide Clinical and Financial Database/Decide System. All discharges in 2007 with specified codes in the primary diagnosis field. All discharges with the specified codes in any of the secondary diagnosis field. This number may be underreported, i.e., not all hospitals submit E codes.

Denominator: Bridged-race Vintage 2007 postcensal population estimates for July 1, 2000-July 1, 2007, by county, single-year of age, Hispanic Origin, and sex.

NOTE: Denominator this year is children 1-14 years; does not include infants. Infants were included in past years.

Narrative:
Injury is a significant public health problem among Ohio youth. Injuries are the leading cause of death and disability for children and youth aged 1-24 in Ohio. Alarmingly, 12.5 per 100 children aged 14 and younger were treated for injuries in ERs in Ohio during 2007. The injury inpatient hospitalization rate for Ohio children aged 14 and younger was 170.2 per 100,000.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	24.8	28.1	26.1	24.2	20.8
Numerator	562	597	549	510	438
Denominator	2264102	2122965	2104949	2104949	2104949
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: Data was provided as a courtesy by the Ohio Hospital Association Clinical and financial Database.

Notes - 2008
Source: Data was provided as a courtesy by the Ohio Hospital Association Clinical and Financial Database.

Notes - 2007
.Data source: Ohio Hospital Association (OHA) Statewide Clinical and Financial Database/Decide System. All discharges in 2007 with specified codes in the primary diagnosis field. All discharges with the specified codes in any of the secondary diagnosis field. This number may be underreported, i.e., not all hospitals submit E codes.

Denominator: Bridged-race Vintage 2006 postcensal population estimates for July 1, 2000-July 1, 2007, by county, single-year of age, Hispanic Origin, and sex.

NOTE: Denominator this year is children 1-14 years; does not include infants. Infants were included in past years.

Narrative:
Injury is a significant public health problem among Ohio youth. Injuries are the leading cause of death and disability for children and youth aged 1-24 in Ohio. Motor vehicle crashed remain the leading cause of injury death for Ohioans aged 5 to 24. The Er visit rate for MVC-related injury among Ohio youth 14 and younger was 185.8 per 100,000, while the inpatient hospitalization rate was 17.4 per 100,000 in 2007.

ODH Injury Prevention program work closely with the Department of Public Safety (DPS) and the Governor's Highway Safety Office to address child passenger safety issues. Child restraint fines and a DPS grant, funds the purchase of educational materials and safety seats that are distributed through a network of programs across the state. ODH Title V program staff participate in the Ohio Injury Prevention Partnership, comprised of stakeholders with interests in injury prevention throughout Ohio.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	120.6	115.6	108.6	91.0	84.6
Numerator	1948	1846	1710	1432	1331
Denominator	1614620	1597458	1573926	1573926	1573926
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over					

the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: Data was provided as a courtesy by the Ohio Hospital Association Clinical and Financial Database.

Notes - 2008
Source: Data was provided as a courtesy by the Ohio Hospitals Association Clinical and Financial Database.

Notes - 2007
Data source: Ohio Hospital Association (OHA) Statewide Clinical and Financial Database/Decide System. All discharges in 2007 with specified codes in the primary diagnosis field. All discharges with the specified codes in any of the secondary diagnosis field. This number may be underreported, i.e., not all hospitals submit E codes.

Denominator: Bridged-race Vintage 2007 postcensal population estimates for July 1, 2000-July 1, 2007, by county, single-year of age, Hispanic Origin, and sex.

Narrative:
Ohio youth aged 15-24 were hospitalized for injury at a rate of 463.8 per 100,000. Motor vehicle crash rates increase substantially for youth aged 15-24,in large part due to increased exposure to youthful driving practices as both a driver and an occupant.

ODH Injury Prevention program work closely with the Department of Public Safety (DPS) and the Governor's Highway Safety Office to address child passenger safety issues. Child restraint fines and a DPS grant, funds the purchase of educational materials and safety seats that are distributed through a network of programs across the state. ODH Title V program staff participate in the Ohio Injury Prevention Partnership, comprised of stakeholders with interests in injury prevention throughout Ohio.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	34.9	32.6	36.9	38.4	39.6
Numerator	13760	12937	14654	15219	15699
Denominator	394433	396845	397127	395973	395973
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

Data Source: Numerator - 2007 Ohio Department of Health Data Warehouse (data submitted by ODH Division of Prevention, State STD Surveillance Program)

Denominator: 2006 Census.

Narrative:
Rates for this Health Status Indicator have trended up since 2005 from 32 to 38 percent. Family planning monitors all ODH-funded family planning centers to assure that all patients 26 years of age and under are tested annually for chlamydia. In 2005, 31,773 patients were tested for chlamydia, compared to 35,474 patients tested in 2009. This increase in the number of patients tested closely follows the increase in the state rate of women 15-19 years of age with a reported case of chlamydia. The Region V, CDC Infertility Prevention Program (IPP) provides laboratory services to test patients under 29 years of age in Ohio to family planning, STD, youth incarceration centers and other institutions. The state provides medications to treat patients with positive tests. This program has lost funding over the last five years and has been forced to focus services for agencies that report at least a 4% positivity rate. This has eliminated these "free" services to many smaller agencies who are hard pressed to afford the testing and medications for their patients.

The Ohio Department of Health Bureau of Infectious Diseases has completed a proposal to change Ohio law to allow for partner expedited treatment for chlamydia. The proposal will be forwarded to department administration and then to the Ohio Medical Board for approval prior to being submitted to the legislature. Current literature supports the predication that this change, when effected, will decrease the number of repeat cases of chlamydia for family planning clients.

The IPP is training staff to provide surveillance and technical assistance to subgrantees to assure that ODH-funded family planning centers test all patients under 26 years of age annually for chlamydia. The Region V, CDC IPP is in the process of reorganization with the goal to provide quality assurance for covered entities to assure appropriate testing for this target population. CDC has been asked to reevaluate their findings regarding in-house chlamydia tests to enable subgrantees to provide same-day test results for patients and their partners to increase treatment rates and to decrease partner infection and patient re-infection rates.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.9	9.0	9.8	9.8	10.5
Numerator	17380	17395	18950	18950	20062
Denominator	1955691	1931954	1933670	1933670	1909116
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final

Notes - 2009
Data provided by ODH Data Center - using 2007 census data.

Notes - 2008
2008 data not available; 2007 data used for 2008 estimates

Notes - 2007
Data Source: Numerator - 2007 Ohio Department of Health Data Warehouse (data submitted by ODH Division of Prevention, State STD Surveillance Program)

Denominator: 2006 Census.

Narrative:
Rates for this Health Status Indicator have trended up since 2005 from 8.2 to 9.8. ODH-funded family planning centers have increased the numbers of patients tested in the period 2005-2009. Program guidelines direct projects to test all women under the age of 26 and any patient over 26 who appears to be a "high-risk" patient-e.g. those with multiple sex partners, history of repeat STIs, recently incarcerated, inconsistent condom use, and pregnancy test patients). The proposed change to Ohio law regarding partner expedited treatment will be useful in decreasing repeat infections for family planning clients and those of their partners.

Forty percent of ODH-funded family planning clients are 25 years and older; most positive chlamydia tests are those for clients 17-24. The population 20-44 will be viewed as having separate needs for the 20-25, with these patients being aggressively tested and testing priority for older clients applied to those who are identified as high risk patients. Program will work with the CDC IPP to provide quality assurance to family planning projects to assure that all patients under 26 are tested annually for chlamydia and that patients 26 years and older and are high risk are tested annually. Program staff will collaborate with ODH Infections Disease (STD) to receive appropriate training to improve monitoring and technical assistance to ODH-funded family planning projects.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	152581	120551	23197	488	3067	74	5204	0
Children 1 through 4	591169	467152	90861	1902	10759	385	20110	0
Children 5 through 9	736968	594355	105430	2026	12205	379	22573	0
Children 10 through 14	759670	613634	112240	1748	11503	292	20253	0
Children 15 through 19	809174	658125	123371	2068	9685	316	15609	0
Children 20 through 24	762549	630796	105294	2060	12821	290	11288	0
Children 0 through 24	3812111	3084613	560393	10292	60040	1736	95037	0

Notes - 2011

Narrative:
"Changes are seen in the demographics of Ohio's child population by race and age. Comparing the youngest with the oldest children in the same year, the proportion of those who are white is decreasing with younger ages, while the proportion of those who are black, Asian or who are more than one race, are increasing with the younger ages. These shifts in demographics may have implications for program planning."

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	145052	7529	0
Children 1 through 4	559025	32144	0
Children 5 through 9	705091	31877	0
Children 10 through 14	732505	27165	0
Children 15 through 19	784695	24479	0
Children 20 through 24	740069	22480	0
Children 0 through 24	3666437	145674	0

Notes - 2011

Narrative:
"Changes are seen in the demographics of Ohio's child population by Hispanic ethnicity and age. Comparing the youngest with the oldest children in the same year, the proportion of those who are Hispanic is increasing. The percentage of infants who are Hispanic is 69 percent higher than the percentage of children age 20 through 24 years. This shift in demographics may have implications for program planning."

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	201	82	102	0	0	0	8	9
Women 15 through 17	4717	2628	1588	10	6	1	228	256
Women 18 through 19	11467	7464	3027	17	33	1	385	540
Women 20 through 34	114800	88399	17011	99	2507	62	1907	4815
Women 35 or older	17407	13970	1915	14	670	14	191	633

Women of all ages	148592	112543	23643	140	3216	78	2719	6253

Notes - 2011

Narrative:
"The Ohio resident live birth rate in 2008 was 12.9 per 1,000, representing a total of 148,592 resident births and a decrease over the period of 1994 to 2008. White women represent the overwhelming majority of all births (112,543), followed by black women (23,643). While births to black women made up only 16% of all births in 2008, births to black girls less than 15 years of age made up 51% of all births in that age group.

By age group, the majority of all births in 2008 were to women aged 20 through 44 years (114,800) however the next highest group was among women aged 35 and older (17,407).

Ohio teens aged 15 to 17 years had a live birth rate of 19.7 per 1,000 in 2008 and was slightly lower than the U.S. live birth rate for the same age group in the most recent year available, 2007, of 22.2 per 1,000.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	183	16	2
Women 15 through 17	4332	319	66
Women 18 through 19	10694	681	92
Women 20 through 34	108813	5265	722
Women 35 or older	16657	606	144
Women of all ages	140679	6887	1026

Notes - 2011

Narrative:
"In 2008, while Hispanics only represented 4.6% of all Ohio live births, this group experienced the highest live birth rate of all racial/ethnic groups examined. Hispanics were also the only group with a marked and statistically significant increase in birth rate across the period from 1994 through 2008 (p=0.000). This finding is consistent with national birth trends. In Ohio in 2008, black and Hispanic teens aged 15 through 17 years each experienced a live birth rate about 3 times that of whites (44.8, 43.3, and 14.8 per 1,000, respectively).

Implications: Hispanic birth outcomes will exert greater influence on overall Ohio birth outcomes assuming the Hispanic population continues to represent an increasing proportion of Ohio births over time. However, although the proportion of all births that were Hispanic increased 2.7 fold between 1994 and 2008, Hispanics still represented only a small proportion of all births in Ohio."

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	1144	680	404	0	6	0	16	38
Children 1 through 4	180	124	41	0	1	0	2	12
Children 5 through 9	95	65	23	0	0	0	0	7
Children 10 through 14	121	86	29	0	2	0	0	4
Children 15 through 19	431	315	108	0	1	0	2	5
Children 20 through 24	633	467	145	0	6	0	0	15
Children 0 through 24	2604	1737	750	0	16	0	20	81

Notes - 2011

Narrative:
Child fatality review (CFR) boards in Ohio's 88 counties review deaths from all causes for all children younger than 18. Boards share findings with local stakeholders and seek collaboration to develop initiatives to prevent injuries/deaths. ODH provides TA, training/tools to local CFR boards on ways to present/share/use information. At the local and state level, data are analyzed by race and ethnicity to identify any disparities that exist for cause and manner of death. In some cases, greater percentages of deaths occur in a specific race relative to their representation in the general population, which is addressed in recommendations for planning prevention programs.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	1102	42	0
Children 1 through 4	170	10	0
Children 5 through 9	88	7	0
Children 10 through 14	118	3	0
Children 15 through 19	419	12	0
Children 20 through 24	606	28	0
Children 0 through 24	2503	102	0

Notes - 2011

Narrative:
Child fatality review (CFR) boards in Ohio's 88 counties review deaths from all causes for all children younger than 18. Boards share findings with local stakeholders and seek collaboration to develop initiatives to prevent injuries/deaths. ODH provides TA, training/tools to local CFR boards on ways to present/share/use information. At the local and state level, data are analyzed by race and ethnicity to identify any disparities that exist for cause and manner of death. In some cases, greater percentages of deaths occur in a specific race relative to their representation in the general population, which is addressed in recommendations for planning prevention programs.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	3049562	2453817	455099	8232	47219	1446	83749	0	2009
Percent in household headed by single parent	34.0	26.0	71.0	0.0	11.0	0.0	0.0	0.0	2008
Percent in TANF (Grant) families	100.0	50.8	47.3	0.1	0.3	0.0	1.2	0.2	2007
Number enrolled in Medicaid	1176531	771688	378687	16	9740	221	13939	2240	2009
Number enrolled in SCHIP	286180	205501	74614	3	2827	66	3041	128	2009
Number living in foster home care	23775	12890	8804	26	31	12	1175	837	2009
Number enrolled in food stamp program	792597	481340	297811	1020	3102	158	5001	4165	2007
Number enrolled in WIC	226316	149187	60983	953	1600	399	12771	423	2008
Rate (per 100,000) of juvenile crime arrests	3639.0	2809.2	8972.4	21877.5	6201.0	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	15.4	10.6	35.7	30.9	7.6	0.0	21.8	0.0	2008

Notes - 2011

Data reflects SFY 2009 Enrollment. A recipient enrolled in both Medicaid (Title XIX) and SCHIP (Title XXI) during the year would be counted in each program. Recipients whose racial indentification changed during SFY 2009 would be counted in each racial group.

Data reflect SFY 2009 Enrollment. A recipient enrolled in both Medicaid (Title XIX) and SCHIP (Title XXI) during the year would be counted in each program. Recipients whose racial identification changed during SFY 2009 would be counted in each racial group.

Data are from 2007-2008 school year and reflect 100% less the high school graduation rates for each race. Native Hawaiian or other Pacific Islander caegory is combined with Asian.

These are the children who were in Foster Care during CY2009. This is unduplicated count of children. If the same child entered Forster Care more than one occasion, he/she is counted only once.

Narrative:
The group of indicators that describe the status of children in various situations or who are enrolled in major social service/health programs are important to the State Title V program, as they provide information that is incorporated into the MCH needs assessment and then monitored in the intervals between major needs assessments. The information allows us to identify and track changes, by race and Hispanic ethnicity, in situations such as single parent families and in program use.

The process of accessing some of the data required for reporting on this section results in the identification of new partners who can be recruited to serve as stakeholders for needs assessment activities and the identification of of strategies to address disparities/gaps in outcomes and services to the MCH population.

The gathering of the data needed for this scetion also presents the opportunity to explore consistency in reporting of race and Hispanic ethnicity data, as not all data sources collect or report this data in the same way.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	2926368	123194	0	2009
Percent in household headed by single parent	58.0	42.0	0.0	2008
Percent in TANF (Grant) families	96.0	4.0	0.0	2007
Number enrolled in Medicaid	1129551	47160	0	2009
Number enrolled in SCHIP	274529	11651	0	2009
Number living in foster home care	19926	804	3045	2009
Number enrolled in food stamp program	877935	34996	0	2008
Number enrolled in WIC	206577	19316	423	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	0.0	35.5	0.0	2008

Notes - 2011
Data reflects SFY 2009 Enrollment. A recipient could have been enrolled in both Medicaid (Title XIX) and SCHIP (Title XXI) during the year and would be counted in each program. Recipients whose ethnic identification changed suring SFY 2009 would be counted in each ethnic group.

Data reflects SFY 2009 Enrollment. A recipient enrolled in both Medicaid (Title XIX) and SCHIP (Title XXI) during the year would be counted in each program. Recipients whose ethnic identification changed during SFY 2009 would be counted in each ethnic group.

Hispanic data are not available.

The Ohio Department of Education collects Hispanic ethnicity as a race, so non-Hispanic ethnicity is not available. Date are from 2007-2008 school year and reflect 100% less the high school graduation rates fro Hispanic ethnicity.

These are the children wo were in Foster Care during CY2009. Thisi s unduplicated count of children. If the same child entered Foster Care more than one occasion, he/she is counted only once.

Narrative:
The group of indicators that describe the status of children in various situations or who are enrolled in major social service/health programs are important to the State Title V program, as they provide information that is incorporated into the MCH needs assessment and then monitored in the intervals between major needs assessments. The information allows us to identify and track changes, by race and Hispanic ethnicity, in situations such as single parent families and in program use.

The process of accessing some of the data required for reporting on this section results in the identification of new partners who can be recruited to serve as stakeholders for needs assessment activities and the identification of strategies to address disparities/gaps in outcomes and services to the MCH population.

The gathering of the data needed for this scetion also presents the opportunity to explore consistency in reporting of race and Hispanic ethnicity data, as not all data sources collect or report this data in the same way.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	2573203
Living in urban areas	2458799
Living in rural areas	757158
Living in frontier areas	0
Total - all children 0 through 19	3215957

Notes - 2011
Provisional data until results of 2010 Census

Provisional data until results of 2010 Census

Provisional data until results of 2010 Census

Provisional data until results of 2010 Census

Narrative:
According to the 2000 Census, 76.5 percent of Ohio's child population lives in urban areas and 23.5 percent live in rural areas. ODH will update this information once the 2010 Census data is released.

For the purpose of data analysis, the Ohio Department of Health often subdivides the urban areas into metropolitan and suburban counties, while the rural areas are subdivided into rural, Appalachian and rural, non-Appalachian counties. The demographics and health outcomes of the populations living in these four county types vary; so programs meant to be implemented across Ohio can be adapted according to county-type characteristics. An estimated 81.1 percent of the population in Ohio resides in metropolitan areas. The Ohio Department of Health typically categorizes the 88 counties as metropolitan (11), suburban (16), rural non-Appalachian (29) and Appalachian (32).

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	11485910.0
Percent Below: 50% of poverty	6.3
100% of poverty	13.4
200% of poverty	30.6

Notes - 2011
Source: 2008 American Community Survey Public Use Microdata Sample prepared by the Census Bureau.
Prepared by: Policy Research & Strategic Planning, Ohio Dept of Development

Source: 2008 American Community Survey Public Use Microdata Sample prepared by the Census Bureau.
Prepared by: Policy Research & Strategic Planning, Ohio Dept of Development

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Prepared by: Policy Research & Strategic Planning, Ohio Dept of Development

Source: 2008 American Community Survey Public Use Microdata Sample prepared by the Census Bureau.
Prepared by: Policy Research & Strategic Planning, Ohio Dept of Development

Narrative:
The data for this indicator are useful in comparing the poverty levels of participants in various health/social service programs with the poverty level of the population as a whole. We would expect to see increased proportions of individuals at lower poverty levels in programs designed to

assist them. If not, outreach would need to be assessed and re-directed.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	3061089.0
Percent Below: 50% of poverty	9.6
100% of poverty	18.6
200% of poverty	38.6

Notes - 2011
Source: 2008 American Community Survey Public Use Microdata Sample prepared by the Census Bueau.
Prepared by: Policy Research & Strategic Planning, Ohio Dept of Development

Source: 2008 American Community Survey Public Use Microdata Sample prepared by the Census Bueau.
Prepared by: Policy Research & Strategic Planning, Ohio Dept of Development

Source: 2008 American Community Survey Public Use Microdata Sample prepared by the Census Bueau.
Prepared by: Policy Research & Strategic Planning, Ohio Dept of Development

Source: 2008 American Community Survey Public Use Microdata Sample prepared by the Census Bueau.
Prepared by: Policy Research & Strategic Planning, Ohio Dept of Development

Narrative:
The data for this indicator are useful in comparing the poverty levels of children in various health/social service programs with the poverty level of the population of children as a whole. We would expect to see increased proportions of children at lower poverty levels in programs designed to assist them. If not, outreach would need to be assessed and re-directed.

F. Other Program Activities

Title V Help Line
A. Since February/1995, DFCHS has operated the Help Me Grow (HMG) helpline, a statewide toll-free 800 number, which provides health and social service referrals and information to callers and is also the toll-free number for Title V programs. Information on programs from the following state agencies is currently available: ODE; ODH; ODJFS; ODMH; and ODMR/DD, as well as local sites for clinical services. The goal of the helpline is to allow for a single, clearly identifiable point of contact to obtain information on state programs and agencies serving families and children.

While ODH continues to market and advertise for the help line other state agencies have discontinued their marketing of this service. Some state and local programs have stopped putting the MCH Helpline number on their materials because they have created their own Hotlines and

Helplines. ODH feels this has resulted in a decrease in the number of calls received by the HMG Helpline. In FY2006 54,951 calls were received; in FY2007 41,088 calls were received; in FY2008 36, 624 calls were received. So there has been a steady decline in the number of calls.

Although there may be a decrease in overall calls ODH believes this service is very beneficial and at times critical to the MCH population. Of the total calls received 10,857 of the calls were transfered to BCMH and resulted in services and/or information being provided to CSHCN consumers or family members. HMG helpline is also collaborating with the Incident Command System to handle incident related calls. The helpline is prepared to take these calls 24 hours a day, 7 days a week and has developed a plan to quickly prepare and respond to calls.

B. Through its BCMH Office, ODH has partnered with and receives major support from consumer and family organizations across the state like the Family to Family Centers:(in collaboration with Family Voices):

Because Ohio is a home rule state with most services administered and delivered on a county basis, Family Voices of Ohio has chosen to support a family to family network, Family to Family Health Information Network(F2FHIN) rather than a single center to provide information, education and peer support to families of CSHCN throughout Ohio. The premise of this initiative is for parent health information specialists (HIS) to be housed in parent organizations throughout the state.

Family Voices of Ohio has established four parent HIS in parent organizations located in four regions of the state. These organizations are: Family Information Network of Toledo (NW Ohio), Parent Coalition for Persons with Disabilities in Akron (NE Ohio), the Early Childhood Resource Network in Columbus (Central Ohio), and Ohio Brain Injury Association (SE Ohio). A fifth organization, The Collaborative of NW Ohio, will serve as fiscal agent for FV of Ohio. These parent organizations have been dedicated to serving all disabilities and diagnoses for many years and have worked closely with other family serving agencies, and are familiar with the cultural and ethnic needs of surrounding communities.

Family Voices of Ohio in collaboration with the designated parent organizations and the BCMH program, identifies and has contracted with parents who are experienced in the complexities of the health care system. These centers are located so that families of CSHCN throughout Ohio are served within their communities.

Parent navigators in each region: 1) partner with the 211 agencies of the surrounding area including the use of interpreter services, 2) work in conjunction with service coordinators from Help Me Grow, BCMH public health nurses, MR/DDs, mental health agencies, and children's hospitals, 3) connect with family support and advocacy organizations, 4) network with local AAP chapters, 5) arrange for trainings in collaboration with BCMH and Family Voices, 6) collaborate with local Benefits Bank counselors to enroll families in public programs like Medicaid, 7) identify and assist cultural groups to address their children's health disparities, 8) and report data regularly.

A key component of Ohio's Family to Family Health Information Network is to initiate and maintain a partnership with Ohio's Title V program, the Bureau for Children with Medical Handicaps. See the attached re

Attached for review is Ohio's Family and Children First Council report on Youth and Young Adults in Transition Steering Committee Strategic Planning Report that addresses the needs of youth including, transition services, housing, college and job placement. The Young Adult Advisory Committee (YAAC) composed of youths aged 16 to 24 who are receiving or have received BCMH

services, advise BCMH of issues facing youth as they transition into adult medical and social services, the Parent Advisory Committee (PAC) composed of parents from around the state who meet regularly to advise BCMH regarding care for children with special health care needs, as well as BCMH staff were instrumental in the development of this plan.

G. Technical Assistance

Technical Assistance Requests (not listed in order of preference or importance):

1. State Performance Measure 04 Issues
Description of Technical Assistance Requested:
Ohio's DFCHS is requesting a multiple- days train-the-trainers cultural and linguistic competence workshop to ensure continuous and uniform site training to staff and local grantees; and give "how to's" for assessing related intervention outcomes.

Reason(s) Why Assistance is Needed:
To expand DFCHS's capacity to reduce health disparities in health outcomes through the delivery of services which are culturally and linguistically competent. Only 10 of 44 DFCHS programs now provide cultural and linguistic competence training.

What State, Organization or Individual Would You Suggest Provide the TA:
We are requesting Technical assistance from the National Center for Cultural Competence.

2. Fetal Infant Mortality Review (FIMR)
Description of Technical Assistance Requested:
Training for local and/or state teams on the development of FIMR programs to analyze factors contributing to fetal and infant death.

Reason(s) Why Assistance is Needed:
Ohio currently does not have the expertise at the state level to provide guidance to local agencies. We would like to be able to provide training to local teams so they can compile and analyze FIMR data.

What State, Organization or Individual Would You Suggest Provide the TA:
The Michigan Department of Community Health has experience in training and supporting local as well as state FIMR teams.

3. State Performance Measure 06
Description of Technical Assistance Requested:
Assistance with the development and implementation of a core set of preconception health indicators that monitor the health of reproductive age women (18-44) and training on how to use these indicators to evaluate preconception health effects.

Reason(s) Why Assistance is Needed:
Ohio has identified the development of a core set of preconception health indicators as a state performance measure. We would like to use the experience of other states that have already developed a list of indicators.

What State, Organization or Individual Would You Suggest Provide the TA:
Representatives from the multi-state consortium who worked to identify a core list of preconception health indicators.

4. State Performance Measure 02
Description of Technical Assistance Requested:
Assistance with the development and implementation of a social marketing campaign specifically targeted to those highest at risk for poor birth outcomes. This proposal seeks to design relevant

and motivational pre-conception and inter-conception messages and their content. Both the messages and their delivery system will be based on market research of different segments of the priority population.

Reason(s) Why Assistance is Needed:
Preconception care has been identified as the area with the most potential to improve birth outcomes. Ohio's IMR of 7.8 (2006)[2], after steadily decreasing for years, has not substantially changed for more than a decade. Ohio's African-American infants die at more than twice the rate of white infants. The IMR in Ohio is the twelfth-highest in the country[3] and exceeds the national goal of 4.5 established by the DHHS in the Healthy People 2010 initiative.

5. MCH Cost Analysis
Description of Technical Assistance Requested:
Development of a comprehensive MCH cost analysis program that can be used by local subgrantees to analyze the cost of providing MCH services at all levels of the pyramid. This will assist both the local subgrantees and ODH in making the most cost effective use of limited MCHBG funds.

Reason(s) Why Assistance is Needed:
With cuts to state and federal grant programs, MCH public health services are being widely curtailed. It is essential to make the best use of all available funds.

What State, Organization or Individual Would You Suggest Provide the TA:
George H.W. "Gerry" Christie
Health Policy Analysts
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V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	21802339	21802339	21938322		22118275	
2. Unobligated Balance *(Line2, Form 2)*	4652992	4652992	3495443		3419327	
3. State Funds *(Line3, Form 2)*	32064483	29960798	33191474		31175158	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	15967790	9585895	11798944		12324474	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	74487604	66002024	70424183		69037234	
8. Other Federal Funds *(Line10, Form 2)*	332038634	306311275	326844439		321146370	
9. Total *(Line11, Form 2)*	406526238	372313299	397268622		390183604	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	8861040	6869910	8405441		7428657	
b. Infants < 1 year old	3867318	2998308	3668476		3242168	

c. Children 1 to 22 years old	24818422	19241569	23542357		20806533	
d. Children with Special Healthcare Needs	36299783	36244849	34283211		37002105	
e. Others	0	0	0		0	
f. Administration	641041	647388	524698		557771	
g. SUBTOTAL	74487604	66002024	70424183		69037234	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		94644		94644	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	283822880		279937903		279937903	
h. AIDS	23881598		23290601		0	
i. CDC	1355585		1314917		1314917	
j. Education	14677053		14497916		14497916	
k. Other						
BlacK Lung	0		0		291000	
Family Planning	0		0		4251624	
Nat'L Student Loans	0		0		440000	
New Born Hearing	0		0		150000	
Other Funds-see note	0		0		18649633	
PRAMS	0		0		146951	
Primary Care	312662		312662		312662	
Rural Flex	673531		591600		591600	
Rural Health	0		167200		167200	
SRHIP	295185		287703		300320	
Black Lung	525547		291000		0	
CDC Birth Defects	180000		336334		0	
Child Care Dev.	0		241000		0	
Nat'l Student Loans	300000		440000		0	
Other Funds See Note	0		789335		0	
Title X	4701397		4251624		0	
Child Care Developme	241020		0		0	
Cleveland AIDS	200000		0		0	
Other Funds-See Note	777532		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	39172202	36503996	38462357		37988021	
II. Enabling Services	14050105	11736206	12716000		12352619	
III. Population-Based Services	7623184	6367359	6899264		6702317	
IV. Infrastructure Building Services	13642113	11394463	12346562		11994277	
V. Federal-State Title V Block Grant Partnership Total	74487604	66002024	70424183		69037234	

A. Expenditures

A. Expenditures

Form 3 -- FFY09

- Ohio will use the un-obligated balance to support MCH activities during the first quarter of the new federal fiscal year until the arrival of the new notice of award.

- The FFY09 Federal-State Title V Block Grant Partnership expenditures were $66,002,024. This is $2,375,257 above the FFY08 expenditures of $63,626,767.

- Overall FFY09 expenditures (including other federal funds) related to MCH activities were $372,313,299. This is $4,422,956 below the FFY08 expenditures of $376,736,255.

Form 4 -- FFY09

- FFY09 expenditures for: pregnant women at $6,869,910; infants at $2,998,308; and children (1-22) at $19,241,569. These are all below the FFY08 expenditure levels for each category.

- FFY 09 expenditures for children with special health care needs of $36,244,849 are above the FFY08 amount of $32,749,927 by $3,494,922.

- The FFY09 administration expenditures were $647,388. This is $248,166 above the FFY 08 expenditures of $399,222. The increase in administrative costs is due to the filling of vacant positions. At 2.9% of total MCH-BG expenditures, the administration costs are well within the 10 percent restriction requirement.

Form 5 -- FFY09

- FFY09 expenditures for: Direct Health Care Services - $36,503,996; Enabling Services - $11,736,206; Population Based Services - $6,367,359; and, Infrastructure Building Services of $11,394,463 are 55.3 percent, 17.8 percent, 9.6 percent, and 17.3 percent of total Federal-State Title V Block Grant Partnership expenditures, respectively.

B. Budget

B. Budget

In light of the limited and often reduced funding at both the state and federal levels, ODH is committed to directing its available resources towards the funding of essential planned programs that address the state's priorities. Maternal Child Health Title V Block Grant funding is essential to ODHs' ability to support its MCH programs and address those priorities. During the planning for the five year needs assessment, Ohio was afforded the opportunity to engage a new compliment of people, examine its data information in new ways, and thoughtfully plan how it will link resources with MCH programs given the changing landscape in Ohio.

Examples of how Ohio has redirected its precious MCH Block Grant resources to address the priorities that resulted from this needs assessment and planning process include: the redirection of the Regional Perinatal Coordinator program to perinatal quality improvement initiative; the shift from a focused lead poisoning prevention programs to a broader healthy homes initiative; and Ohio is also capitalizing on several other funding opportunities, primarily from HRSA, to augment the investment in addressing these very important priorities for our state.

While most block grant funding is for continuing MCH programs and activities, some of the funding is being used for developmental/new projects. The expectation is that those projects will evolve into operational entities or have completed their original purpose in keeping with their stated goals. This funding approach allows continuation funds to be used to begin new innovative projects that align with the state priorities.

3.3 Annual Budget and Budget Justification

Summary Budget Description for FY2011

- Component A: Services for Pregnant Women, Mothers and Infants up to age one year
- Component B: Preventive and Primary Care Services for Children and Adolescents
- Component C: Family-Centered, Community-Based, Coordinated Care and the Development of Community-Based Systems of Care for Children with Special Health Care needs and their families.
  - Component A: $3,700,349
  - Component B: $ 10,634,073
  - Component C: $ 7,225,952
  - Subtotal: $21,560,374
  - Administrative Costs: $ 557,901
  - GRANT TOTAL: $22,118,275.

* Administrative costs are applied proportionally to Components A, B and C.

Budget Justification

- Services for Pregnant Women, Mothers and Infants to Age One
  - In its FFY 2011 request, Ohio has budgeted $92,711,621 for services for Pregnant Women, Mothers and Infants to Age One; 23.76 percent of the total funds ($390,183,604) targeted for Title V related activities. For this component, MCH Block Grant funds total $3,700,349 which is 16.73 percent of the FFY 11 MCH Block Grant request of $22,118,275. Other State and Federal funds for this component total $89,011,272 or 24.18 percent of the budgeted $368,065,329 in other Title V related funds.

- Preventive and Primary Care Services for Children and Adolescents

o In its FFY2011 request, Ohio has budgeted $255,744,414 for Preventive and Primary Care Services for Children and Adolescents or 65.54 percent of the total funds ($390,183,604) designated for Title V and related activities. For this component, MCH Block Grant funds total $10,634,073 which is 48.08 percent of the FFY 11 MCH Block Grant request of $22,118,275. Other State and Federal funds for this component total $245,110,341 which is 66.59 percent of the $368,065,329 of other Title V related funds.

- Children with Special Health Care Needs

o In its FFY2011 request, Ohio has budgeted $41,083,420 for activities for Children with Special Health Care Needs or 10.53 percent of the percent of the total funds ($390,183,604) budgeted for Title V and related activities. For this component, MCH Block Grant funds total $7,225,952 which is 32.67 percent of the FFY 11 MCH Block Grant request of $22,118,275. Other State funds for CSHCN total $33,857,468 which is 9.2 percent of the $368,065,329 of other Title V related funds.

- Administrative Costs

o $557,901 or 2.52 percent of the requested FFY 11 MCH BG funds.

- Maintenance of State Effort

o In 1989, Ohio's MCH Block Grant award was $19,369,474 and the state provided $23,812,983 in support of the MCH activities. The fiscal year 2011 federal MCH award is expected to be $22,118,275 and the state will provide $33,191,474. State support is provided by appropriations from several state line items and one source of county funds which the Division is authorized to spend on behalf of children with special health care needs. The particular line items and their level of funding in 1989 and 2010 are shown below:

Description	1989	2010
Sickle Cell Control	$421,347	$1,035,344
Genetic Services	$1,144,281	$918,227
Child & Family Health Services	$5,652,423	$4,338,449
Adolescent Pregnancy	$400,000	$0
Medically Handicapped Children	$4,682,744	$8,762,451
Cystic Fibrosis	$325,394	$0
Medically Handicapped Audit Funds	$1,312,168	$3,693,016
Medically Handicapped County Funds	$9,874,626	$17,320,687
Totals	$23,812,983	$36,068,174

To determine the total amount of state match and funding of MCH programs, the Division of Family and Community Health Services (DFCHS) totals several of the state appropriation line items which are dedicated to Title V related activities. The authorization levels of the line items are determined by the State Legislature as part of the biennial budget process, but actual expenditures may depend upon executive order reductions, reimbursement limits and revenue limitations.

The above Maintenance of Effort chart lists the 2011 state appropriations as outlined in the

appropriations bill. The cystic fibrosis appropriation line item is no longer shown as match/maintenance of effort because they are dedicated to the provision of services to adults. Services for children with cystic fibrosis are supported by other state CSHCN funds.
One million, two hundred thousand dollars ($1,200,000) of the state Child and Family Health Services appropriation is not included as match for the Title V award because it is designated as part of a state initiative called Women's Health (previously dedicated to family planning services).

An additional $2,686,688 of General Revenue Funds are set-aside for Federally Qualified Health Centers (FQHSs) and are not included on Form 424, Line 15c as match to Title V funds. These funds are included in Line 15e because the population to be served is broader than the population served by MCH funds.

Ohio's maintenance of effort has decreased by $2,974,561 from $39,042,735 in 2010 to $36,068,174 in 2010. The major reason for this decrease in funding for the Child and Family Health Services is due to the states General Revenue Funds (GRF) line item. Ohio continues to experience a drop in expected revenue receipts. This continues to have an impact on the amount of GRF available to support MCH and other state initiatives.

In CY 07, The Ohio Department of Health received the first reimbursement under the Medical Administrative Claiming program (MAC). To date, 33 counties have established the MAC program at the local level. The department continues to encourage the expansion of the MAC program at the local level as a means of off-setting decreasing state revenues. Funds earned under this program are being used by the department and local health departments to support Title V activities.

Rate Agreement
- STATE AND LOCAL DEPARTMENT/AGENCIES
- EIN NO: 1-316402047-A1
- DEPARTMENT/AGENCY: Ohio Department of Health Date: September 18, 2007

246 North High Street
P.O. Box 118 FILING REF: The preceding
Columbus, Ohio 43266-0118 Agreement was dated 9/25/07

- The rates approved in this Agreement are for use on grants, contracts and other agreements with the Federal Government subject to the conditions in Section III.

SECTION I: INDIRECT COST RATES

Type	From	To	Rate	Locations	Applicable to
Prov.	7/1/09	6/30/10	30.5%	On Site	Unrestricted (1)
Fixed	7/1/10	Until Amended	33.1%	On Site	Unrestricted (1)
Fixed	7/1/10	6/30/11	15.1%	On Site	Restricted (2)
Fixed	7/1/06	6/30/07	15.1%		On Site Restricted (1)

*Restricted rate is for U.S. Department of Education Programs which requires the use of a restricted rate as defined by 34 CFR Parts 75.563 & 76.563.
1) Base -- Direct salaries and wages including all fringe benefits.
2) Base -- Total direct costs excluding capital expenditures (building, individual items of equipment, alterations and renovations, sub-awards and flow-through funds).

Administrative Costs
- The administrative costs of Ohio's 2011 MCH Block Grant request are based on budget

and expenditures related to the Operational Support Section of the Division Chief's office. The Operational Support Section is responsible for administrative activities (e.g., grant processing, purchasing, personnel, etc.) associated with MCH and MCH related programs.

FFY2010 Carry Over Funds

- The amount of carryover funds is based on the total amount of funds available in FFY 2010 less projected expenditures through September 30, 2010. In FFY2010 a total of $25,433,765 in MCH Block Grant funds were available to the State of Ohio. According to the State's accounting reports, which reflect activity through May 19, 2010, the projected FFY2009 MCH expenditures will total $22,014,438. When total available funds are reduced by total projected expenditures the unencumbered balance will be $3,419,449.

- The Ohio Maternal and Child Health Programs support the authority of states to use unobligated funds in the next fiscal year. This authority, set forth in section 503 (b) of Title V, has been a cornerstone to enable state MCH agencies to provide funding stability in their local partners and flexibility in the design of statewide programs. Ohio's experience has been that the projected lapsed amount is equal to approximately 1.5 months worth of its 1st quarter expenditures.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.